

MERGING THE MILITARY HEALTH SYSTEM (MHS) AND THE VETERANS HEALTH ADMINISTRATION (VHA) INTO A SINGLE GOVERNANCE STRUCTURE

BY

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MERGING THE MILITARY HEALTH SYSTEM (MHS) AND THE VETERANS HEALTH ADMINISTRATION (VHA) INTO A SINGLE GOVERNANCE STRUCTURE

INTRODUCTION

The Department of Defense (DoD) and Veterans Affairs (VA) healthcare systems are large, complex organizations with a combined Fiscal Year (FY) 2008 budget of over 76 billion dollars. There are over 300,000 personnel in both systems, treating nearly 13.5 million beneficiaries at more than 1,600 sites worldwide.¹ Both Federal healthcare systems face the challenges of healthcare systems everywhere - new practices, techniques, and tools, changing demographics, aging infrastructure, and increasing costs. Yet despite the similar challenges and legislative mandates to work together, the actual amount of cost savings produced by DoD/VA sharing agreements historically remains miniscule when compared to the total annual budgets.²

I assert that until a single management or governance structure is clearly established from a national authority, the extent and success of collaboration efforts between DoD and VA healthcare systems will remain limited by existing public laws and subject to the inherent bureaucracy of the two organizations. More than twenty years of legislative mandates to increase DoD/VA collaboration and the findings of multiple Government Accountability Office (GAO) reports and other Presidential Commission studies support this premise. While both Departments clearly understand the urgency and have taken real strides to increase collaboration, truly seamless health care, provided at a reduced cost, will never be achieved until a single governance structure - or a single line of authority - is established.

Current national attention focusing on the increasing cost, duplication of DoD and VA healthcare services, and difficulties experienced by OEF/OIF veterans transitioning from the DoD to the VA healthcare systems enhance the relevance and urgency of the single governance issue. As of March 2007, the Veterans Healthcare Administration (VHA) coordinated the transfer of over 6,800 severely injured or ill active duty service members and veterans from DoD to the VA.³ As of the first half of FY 2007, approximately 263,900 returning veterans have sought care from VA medical centers and clinics.⁴ The Congressional Budget Office (CBO) estimates the total cost to provide health care to OEF/OIF veterans with service connected conditions to be between \$7 and \$9 billion over the next ten years. Attempts to address these issues help explain the comprehensive

legislative guidance for mandated DoD/VA collaboration contained in the FY 2008 National Defense Authorization Act (NDAA).⁵

Single governance structure would also resolve inconsistent DoD/VA planning for future healthcare delivery, new healthcare facilities and limited resource sharing experienced at local as well as national levels. For example, Carl R. Darnall Army Medical Center (CRDAMC) at Fort Hood, Texas, and the Central Texas Veterans Healthcare System (CTVHCS) are two large Federal medical centers located approximately 25 miles apart. The facilities have historically maintained a very limited amount of interaction even though both have major construction projects planned. Additionally, CRDAMC has the largest Warrior Transition Units (WTUs) in the Army; approximately 30 percent of these service members will migrate to the VA healthcare system, confirming that central Texas is one of the fastest growing geographic regions for eligible veterans. Both facilities purchase care from a large private sector healthcare system instead of first looking to their nearby Federal partner to meet the demand. Despite these interrelated challenges and legislative mandates for DoD/VA sharing, there remains limited senior leadership interaction and no joint strategic plan for a shared future (See Annex A).

Obviously, merging the DoD/VA healthcare systems into a single governance structure multiplies complexity even at the local level. Myriad second and third order effects exist, but they should not rule out efforts to consider the concept's merits. Change in the Federal Government on this scale has recently happened as evidenced by the creation of the Department of Homeland Security (DHS) on November 25, 2002. Large scale change has also recently happened internal to the DoD healthcare system when the Deputy Secretary of Defense Gordon England established the Joint Task Force National Capital Region Medical In September 2007.

For the purposes of this paper, single governance is defined as a body with both executive and budget authority over both DoD and VA medical assets. Current public law would need to be changed for this concept to be realized. Additionally, the single line of authority would only include DoD's TRICARE Management Activity (TMA) and the VA's Veterans Health Administration (VHA) programs and assets. The proposed unified governance structure would exclude the "go to war" or tactical medical components of the Armed Forces, although those tactical components could still provide relevant care, as well

as Veterans Benefits Administration and National Cemetery Service of the Department of Veterans Affairs.

BACKGROUND ON THE TWO HEALTH SYSTEMS

Both DoD and VA healthcare systems share the goal of providing as much care and service as possible to their designated beneficiaries within their allocated budgets. Both systems are considered by Congress to be discretionary spending and require an annual appropriation bill. Discretionary spending is typically set by the House and Senate Appropriations Committees and their various sub-committees. Since the spending is typically for a fixed period, it is said to be under the discretion of the Congress.⁶ There have been several unsuccessful legislative efforts (H.R. 2319 -108th Congress, H.R. 515 – 109th Congress) to make VA health care mandatory spending - similar to Medicare, Medicaid and TRICARE for Life - but the resolutions usually never make it out of committee hearings. Rep. Phil Hare (D-IL) sponsored the latest effort, House Resolution (H.R.) 2315, referred to the Subcommittee on Health on May 29, 2007.⁷

Eligibility requirements for access to health care in both systems are defined by 10 United States Code (U.S.C.) for Department of Defense beneficiaries and 38 U.S.C. for Department of Veterans Affairs beneficiaries. A significant difference between the DoD and VA eligibility requirements is that 38 U.S.C. gives the Secretary of Veterans Affairs the authority to define priorities for access to care through enrollment eligibility decisions (See Annex B).

The Departments' mission statements demonstrate the principal difference between the two healthcare systems. DoD's mission statement highlights its medical readiness mission which is enhanced by operating an extensive health plan (TRICARE) with a network of providers providing health care to a younger, healthier beneficiary population. The VA's statement focuses on running a healthcare system, including nursing homes and residential rehabilitation facilities, dedicated to meet the needs of a predominantly older, male veteran population. Unlike DoD, the VA's healthcare system does not operate a TRICARE-like benefits plan and is generally considered a closed system, meaning the majority of care is provided within the "walls" of its system of facilities.

Military Healthcare System (MHS)

The Department of Defense (DOD) Military Health System (MHS) is comprised of five entities: Health Affairs (HA), TRICARE Management Activity (TMA), and the medical components of the Army, Navy, and Air Force.⁸ Arguably one of the largest and most complex health care organizations in the world, its global infrastructure includes 63 inpatient facilities, 1,087 medical, dental, and veterinary clinics, and almost 131,000 military and civilian personnel providing medical services to 9.1 million eligible beneficiaries.⁹ The FY 2008 defense budget allocates \$38.7 billion to providing health benefits to military personnel and their family members.¹⁰

In support of the DoD readiness mission, the Military Health System (MHS) ensures the Nation has a medically ready, healthy fighting force supported by a combat ready healthcare system that provides a health benefit to its broad customer base. The MHS mission is to: maintain readiness by providing medical services and support to the Armed Forces during military operations and to provide medical support to their dependents and other beneficiaries entitled to DoD health care.¹¹

Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA)

The Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA) oversees the DoD's medical mission. The ASD (HA) reports to the Under Secretary of Defense for Personnel and Readiness (USD/P&R) under the Office of the Secretary of Defense (OSD). HA issues policies, procedures, and standards for TRICARE. It also develops Military Health System (MHS) initiatives to improve the quality of healthcare across the DoD and prepares the DoD healthcare budget.¹²

TRICARE Management Activity (TMA)

TMA manages and executes the Defense Health Program (DHP) appropriation and the DoD Unified Medical Program and supports the Uniformed Services implementation of the TRICARE program. TMA ensures that the DoD healthcare policy is implemented consistently, effectively, and efficiently across the MHS. In addition, it oversees the TRICARE managed care program. Both HA and TMA work together to execute and manage healthcare policies and programs within the DoD. Although TMA utilizes the military healthcare system as the main delivery system, it also uses a civilian network of providers and facilities that serves the uniformed services, retired military, and their families worldwide. Three TRICARE

Regional Offices (TROs) and multiple TRICARE Area Offices (TAOs) support TMA's day-to-day functions.¹³

The Medical Components of the Services

Military healthcare within each of the Services is spearheaded by medical divisions within the Army, Navy, and Air Force through the Army Medical Department (AMEDD), the Navy Bureau of Medicine and Surgery (BUMED), and the Air Force Medical Service (AFMS), respectively. AMEDD and BUMED maintain command of the Medical Force, deploy mission support in theater, and provide beneficiary medical care. The Air Force manages and commands similar medical responsibilities throughout the tactical command or "line."¹⁴ The Service medical components contribute to the MHS readiness missions by operating Medical Treatment Facilities (MTFs), recruiting, equipping, and training an able and ready Medical Force, and supporting operational readiness through DoD's Force Health Protection. The Army, Navy, and Air Force individually maintain Active Duty and Reserve Component officer and enlisted corps for deployment and staffing at the Service-specific MTFs. Each Service also maintains a Federal civilian medical workforce at the Service-specific MTFs. In addition to recruitment and retention, the Services provide education, leadership development, and other training programs to support MHS needs.¹⁵

DoD Healthcare Plan (TRICARE)

TRICARE is the DoD medical and dental programs operating pursuant to chapter 55 of 10 U.S.C. under which medical and dental services are provided to DoD health care beneficiaries. (The term "TRICARE" includes all activities described in the definition of the term "TRICARE Program" at 10 U.S. C. 1072(7).¹⁶) The TRICARE health care plan uses military health care as the main delivery system, augmented by a civilian network of providers and facilities serving our Uniformed Services, their families, retired military, and their families worldwide. TRICARE's mission statement is "To enhance the Department of Defense and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care."¹⁷ TRICARE is administered through a direct care system supported by a civilian network via three regional Managed Care Support Contracts (MCSCs).

Individuals have access to different levels and types of benefits depending on their beneficiary status. Active-duty service members must go to military medical treatment

facilities for their primary care, Family members of active-duty personnel as well as military retirees and dependents who are not eligible for Medicare can choose from one of three main options. Medicare eligible beneficiaries who pay MEDICARE Part B (Medical Insurance) are automatically enrolled in the TRICARE for Life program.¹⁸

- *TRICARE Prime* is similar to a civilian health maintenance organization (HMO). Beneficiaries are enrolled to a managed care health plan and assigned to a primary care manager, who coordinates all aspects of their medical care.
- *TRICARE Standard* is a fee-for-service plan that allows beneficiaries to seek care from any civilian provider and be reimbursed for a portion of the costs after paying co-payments and meeting deductibles. For some services, beneficiaries are required to seek care first from a military medical treatment facility when possible.
- *TRICARE Extra* is similar to a civilian preferred provider organization. Beneficiaries are not enrolled to a health plan but pay lower co-payments than they would under TRICARE Standard if they seek care from a provider in the TRICARE network.
- *TRICARE for Life (TFL)* is available to Medicare-eligible military retirees and their family members and survivors who are enrolled in Medicare Part B. For services covered by both Medicare and TRICARE, Medicare acts as the first payer and TRICARE pays the remaining out-of-pocket costs. Unlike the other TRICARE programs, TRICARE for LIFE is an entitlement program so it does not require annual renewals by Congress.

Veterans Health Administration (VHA)

The Veterans Health Administration (VHA) is the component of the United States Department of Veterans Affairs (VA) that implements the medical assistance program of the VA. VHA mission statement: "The mission of the Veterans Healthcare System is to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services."¹⁹

Using 21 Veterans Integrated Service Networks (VISNs) that report directly to the Office of the Under Secretary for Health, the VHA operates a system of 153 independent VA medical centers, 822 ambulatory care and community-based outpatient clinics (CBOCs), 136 nursing homes, 45 residential rehabilitation treatment programs, and 92 comprehensive home-based care programs.²⁰ With a FY 2008 medical care budget of approximately \$35

billion, the VHA provides health care to more than 5.1 million veterans and more than 400,000 other patients. VHA directly employs more than 200,000 full time equivalent employees, including over 13,000 physicians and nearly 55,000 nurses.²¹

VHA has a comprehensive array of services for disabled veterans, including state-of-the-art treatment for spinal cord injury, blindness rehabilitation, chronic mental illness, traumatic brain injury, amputations, brain dysfunction, post-traumatic stress disorder (PTSD), and substance abuse. Nine VHA research centers of excellence conduct studies emphasizing wheelchair design and technology, brain rehabilitation, spinal cord injury and multiple sclerosis, early detection of hearing loss, orientation techniques for blind persons, amputation prevention and joint replacement. In addition, VHA has the largest network of homeless assistance programs in the country.²²

In addition to its medical care mission, the VHA is the nation's largest provider of graduate medical education and a major contributor to medical and scientific research. VA partners with 107 medical schools and 2,000 colleges or universities. More than half of the nation's practicing physicians receive all or part of their training in VHA and more than 125,000 volunteers, 85,000 health profession trainees, and 25,000 affiliated medical faculties also comprise an integral part of the VHA community.²³

VHA Enrollment

According to Congressional Budget Office (CBO), there are 7.9 million veterans enrolled in the VA medical system.²⁴ Following the passage of the Veterans' Health Care Eligibility Reform Act (VERA) of 1996, VA's mission moved from primarily treating veterans with service-connected disabilities and indigent veterans to offering a comprehensive health benefit to all enrolled veterans. The Veterans' Millennium Health Care and Benefits Act, enacted in 1999, further increased demand by expanding benefits.²⁵ Since funds are limited, VA established priority groups to make sure that certain groups of veterans are able to be enrolled before others (See Annex B).²⁶

By Federal law, eligibility for benefits is determined by a system of eight Priority Groups. Retirees from military service, veterans with service-connected injuries or conditions rated by VA, and Purple Heart recipients constitute the higher priority groups. Veterans without rated service-connected conditions may become eligible based on financial need, adjusted for

local cost of living. Veterans who do not have service-connected disabilities totaling 50 percent or more may be subject to co-payments for any care they received for nonservice-connected conditions.²⁷

Project HERO Program

In FY 07, the VA spent approximately \$3.3 billion dollars on purchased care for veterans' healthcare needs. In response to legislative direction to focus on cost-effective purchasing of care, the VA is developing a TRICARE-like network of providers. The effort is called Healthcare Effectiveness through Resource Optimization or Project HERO.²⁸

DoD/VA SHARING BACKGROUND

As separate agencies of the Federal government, DoD and VA traditionally enjoyed separate Congressional oversight and budget processes as well as totally separate leadership and administration. However, the inescapable logic of efficiencies, effectiveness, and economies of scale possible from a joining of the two systems prompted a continuing theme of both legislative and administration interest. For more than two decades, Congress and the Executive Branch made numerous efforts to increase collaboration between the two Departments in order to provide the most efficient and cost effective health care for eligible beneficiaries (See Annex C).

In 1982, Congress enacted the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Public Law (P.L.) 97-174, 38 U.S.C. 8111 (Sharing Act) to promote more effective DoD/VA sharing.²⁹ In 1996, Congress established the Commission of Service Members and Veterans Transition Assistance to conduct a comprehensive review of all programs that provide benefits and services to veterans. Three years later the Commission released a very detailed report that questioned whether the DoD and VA healthcare systems could survive as separate entities and provided the following recommendations to improve the viability of both systems.³⁰

- Joint procurement of pharmaceuticals, medical and surgical supplies, and medical equipment.
- Interoperable clinical, management and financial information systems.
- Joint procurement of health information technology.
- Development of compatible cost accounting systems and a joint resource allocation and budgeting process.

- Combined funding of graduate medical education.
- Recognition of VA medical centers as equivalent to MTFs in DoD's TRICARE program for military retirees and dependents.
- Combined policy staff and process to review health facilities construction requirements.

In May 2001, legislative inquiries intensified when President George W. Bush signed Executive Order 13214 creating the President's Task Force To Improve Health Care Delivery for Our Nation's Veterans.³¹ The mission of the President's Task Force (PTF) was to "identify ways to improve health care delivery to VA and DoD beneficiaries through better coordination and improved business practices."³² Contained in the very thorough final report published in 2003 was the PTF's finding that "efforts to increase VA/DoD sharing and collaboration, and thereby improve veterans' access to care, until very recently have been at best marginal, or at worst, superficial."³³

Since the 2003 study, there have been more than twenty Government Accountability Office (GAO) and other studies on multiple aspects of DoD/VA healthcare (See Annex D). Examples of more comprehensive studies include the Presidential Task Force on Returning Global War on Terror Heroes in March 2007 and the recent President's Commission on Care for America's Returning Wounded Warriors completed on July 31, 2007. At the risk of oversimplification, each study called for increased DoD/VA collaboration to improve access, efficiency and enhance the transition of separating injured service members to the VA healthcare system.

The senior leadership of both the VA and DoD clearly understand the urgency of the collaboration issue. The FY 2004 NDAA, Public Law (P.L.) 108-136 created the DoD/VA Joint Executive Council (JEC) co-chaired by VA Secretary and the Under Secretary of Defense for Personnel and Readiness.³⁴ The JEC provides executive and overarching leadership of all VA/DoD collaborative activities, including the development of interoperable electronic medical records. Since 2003, VA and DoD have documented these activities in the DoD/VA Joint Strategic Plan (JSP) that is maintained by the JEC.³⁵

VA's Under Secretary for Health and the DoD Assistant Secretary of Defense for Health Affairs co-chair the VA/DOD Health Executive Council (HEC), a subcommittee of the JEC. The HEC coordinates those joint activities related to health care and ensures that the ongoing partnership optimizes health delivery to veterans and military beneficiaries. The

HEC Information Management and Information Technology Work Group, co-chaired by the VHA Chief Information Officer for Health Information Technology Systems and the Military Health System Chief Information Officer, maintains day to day responsibility for health information technology work and, most importantly, for the implementation of joint electronic health record and data sharing initiatives.³⁶ Exhibited in Figure 1 are the other joint workgroups and offices which report to either the HEC or the VA/DoD Benefits Executive Council (BEC).

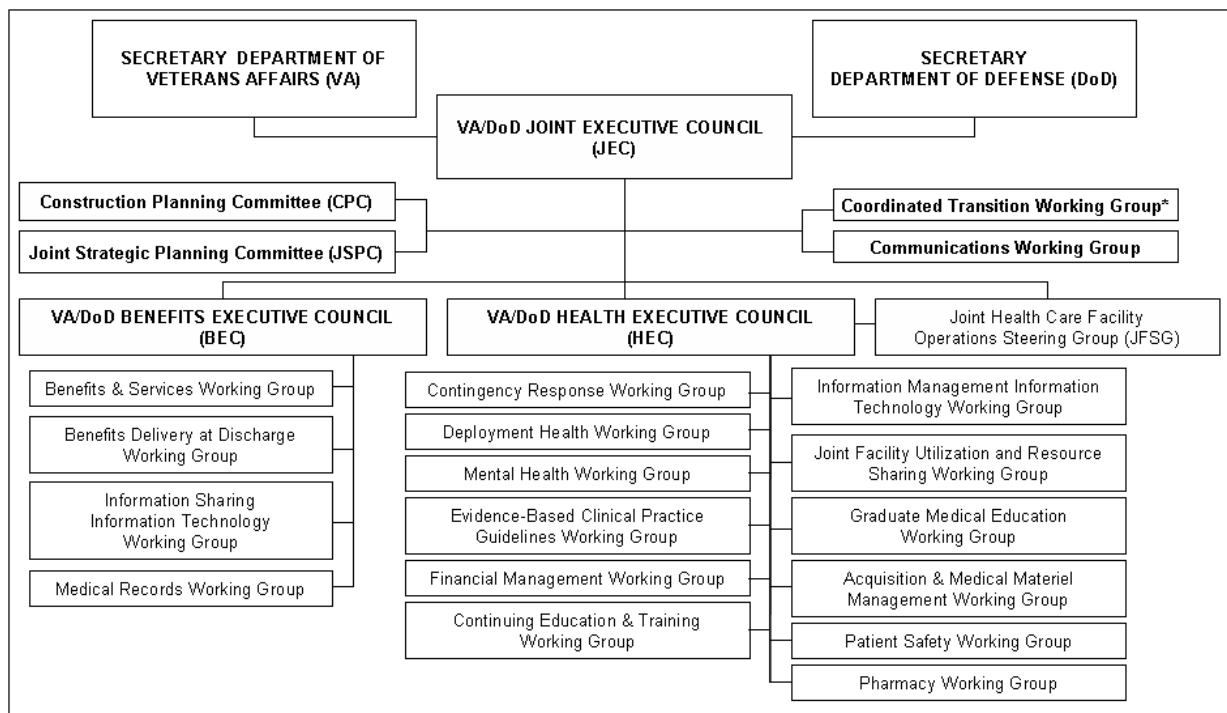


Figure 1. Joint Executive Council Structure

Senior Oversight Committee (SOC) and Lines of Action (LOA)

Depicted in Figure 2 is the organizational wiring diagram of the Senior Oversight Committee (SOC). The SOC was created as a temporary organization to efficiently address the DoD/VA sharing and coordination issues identified in the Dole-Shalala commission and the findings and recommendations of other studies. The Overarching Integrated Product Team (OIPT) was formed to better coordinate, integrate, synchronize, and communicate DoD/VA joint efforts in order to resolve issues either internally identified or directed by legislative mandate. DoD and VA personnel are formed into integration teams and further divide into eight Lines of Action (LOA) to address specific issues. Once the mission of the

SOC is complete, oversight of the initiatives will be transferred to other groups reporting to the JEC.

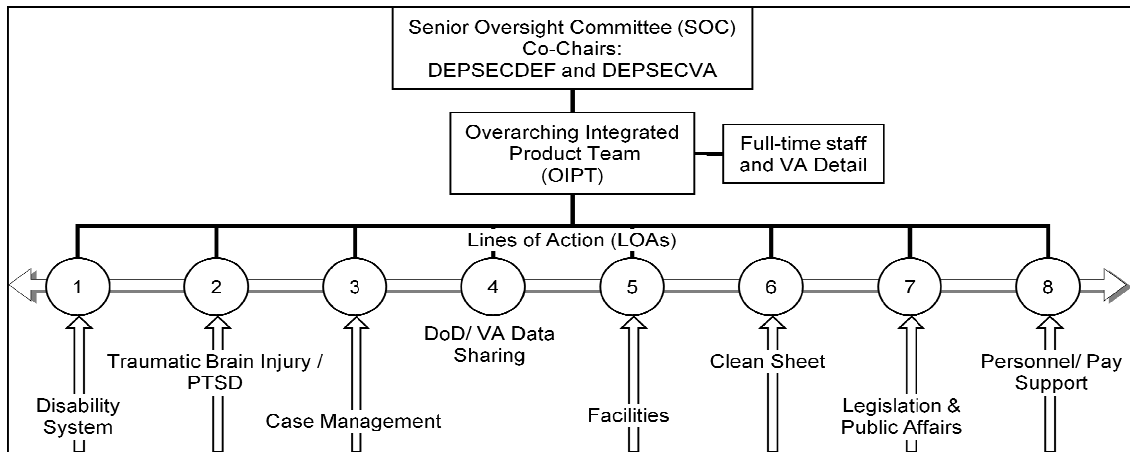


Figure 2. Senior Oversight Committee (SOC) and Overarching Integrated Product Team (OIPT)

Joint Incentive Fund (JIF)

The FY 2003 NDAA also required the DoD and VA to establish a Joint Incentive Fund (JIF) program. The intent of the program is to identify, fund, and evaluate creative local, regional, and national sharing initiatives. A DoD/VA Memorandum of Agreement (MOA) signed on July 8, 2004, assigned VA as administrator of the fund under the direction of the VA/DoD Health Executive Council (HEC). Both the VA and DoD are required to contribute \$15 million each year from FY 04 through FY 2007. The John Warner National Defense Authorization Act for FY 2007 extended the requirement until FY 2010.³⁷

Departmental Coordination Offices

To assist with the implementation of multiple legislative mandates and recommendations for increased sharing, each Department has established separate interagency coordination offices. In FY 2002, TRICARE Management Activity established the DoD/VA Program Coordination Office. The primary purpose of the office is to serve as the central entity within HA/TMA to monitor all VA/DoD Health Care Resource Sharing activities, to include: Pharmacy, Materiel Management, Health Information Management and Technology, Financial Management, Clinical Activities, National Level Interagency Agreements, TRICARE/VA Contractor Relationships, Joint Ventures, and Health Systems Studies and develop and publish a comprehensive implementation plan that provides guidance to MTFs

on all aspects of the program.³⁸ On July 24, 2006 the VA established the DoD Coordination Office and named Edward C. Huycke, MD as the chief. His office supervises VHA/DoD sharing and integration activities. The VA's Office of Policy and Planning and the Assistant Secretary has overall supervision of VA/DoD sharing efforts and is led by Admiral (Ret) Patrick Dunne.

DoD/VA Sharing Programs

The intent of the Sharing Agreement Program is to ensure the optimum use of DoD and VA medical treatment facilities (MTFs) resources and services within the same geographic area. Sharing between the DoD/VA falls into three general categories: National Sharing Initiatives, Joint Ventures, and Local Sharing Agreements. National Sharing Initiatives are overarching agreements applicable to all DoD and VA facilities. An example is the joint purchase of pharmaceuticals for nationwide distribution.³⁹ Joint Venture Agreements are locally negotiated partnerships with a specific management concept (i.e. the collocation or integration of services), usually involving a capital expenditure, to support an increased level of beneficiary services to achieve an economy of scale. In FY 2007, there were eight Joint Venture locations and DoD is generally considered to be the lead agency in the majority of the Joint Venture initiatives.

To encourage greater cooperation, the Sharing Act authorizes local VA Medical Centers (VAMCs) and Military Treatment Facilities (MTF) commanders to enter into Local Sharing Agreements. There is a requirement to get the VISN Director's concurrence and the VHA Under Secretary of Health's approval before a VA facility can enter into a sharing agreement. The majority of the DoD sharing agreements are approved by the next higher commander. While the approval process does not remove all bureaucratic obstacles, the delegation of the authority recognizes the fact that "all health care is local" and provides opportunities for greater innovation. While the decentralization of authority is intended to enhance collaboration it also subjects the success/failure of collaboration efforts to the personalities and vision of the organizations' leaders. Additionally, sharing program agreements are primarily based on utilizing excess capacity. With competing demands for analysts' time, the identification of excess capacity to increase DoD/VA sharing may not be a priority at all levels.

Measuring the Value of the Resource Sharing

The Sharing Act (P.L. 97-174) requires the VA and DoD to jointly report to Congress on the status of VA/DoD sharing activities. While both the DoD and VA have consistently reported the general merits of the sharing program, quantifying the true cost avoidance/savings from the agreements, especially resource sharing agreements negotiated at the local levels, has proven to be difficult. In a December 2001 study commissioned by the VA, The Eagle Group, LLC found that the difficulties in determining the true cost avoidance produced by local agreements stems from a lack of a standard methodology to define cost avoidance/savings; the questionable accuracy of the sharing agreement database; and the inability to establish a baseline from which to identify trends in the level of resource sharing over the years. The Eagle Group found it was possible to measure cost avoidance produced from national sharing initiatives, as opposed to local ones, and believed this type of initiative had the greatest potential for increased cost avoidance.⁴⁰ Examples of DoD/VA national sharing initiatives are the previously discussed discounted rate for jointly purchased medical supplies which produced a cost avoidance of \$40 million in FY 2000 and the joint procurement discounts for DoD/VA pharmaceuticals that resulted in a cost avoidance of approximately \$98 million in FY 2001.⁴¹

Analysis of the DoD/VA Resource Sharing Programs

In FY 2007, 100 VA Medical Centers (VAMCs) were involved in direct sharing agreements with 124 DoD medical facilities for a total of 280 direct sharing agreements that covered 148 unique services.⁴² It should be noted that some of the 280 direct sharing agreements referenced above includes “master agreements” for multiple services. For example, Tripler Army Medical Center and the Pacific Islands Healthcare System are considered to have one direct sharing agreement (2003-FRS-0024) but further analysis reveals this agreement actually contains 23 individual or sub-agreements for various services. Separating the sub-agreements from the master agreements for all sharing participants identifies 638 unique agreements between VA, DoD, and other agencies (see Chart 1). While 638 active agreements involving 224 DoD and VA medical facilities may seem like progress, the total sharing remains miniscule when compared to the aggregate number of facilities in both the DoD and VA healthcare systems.

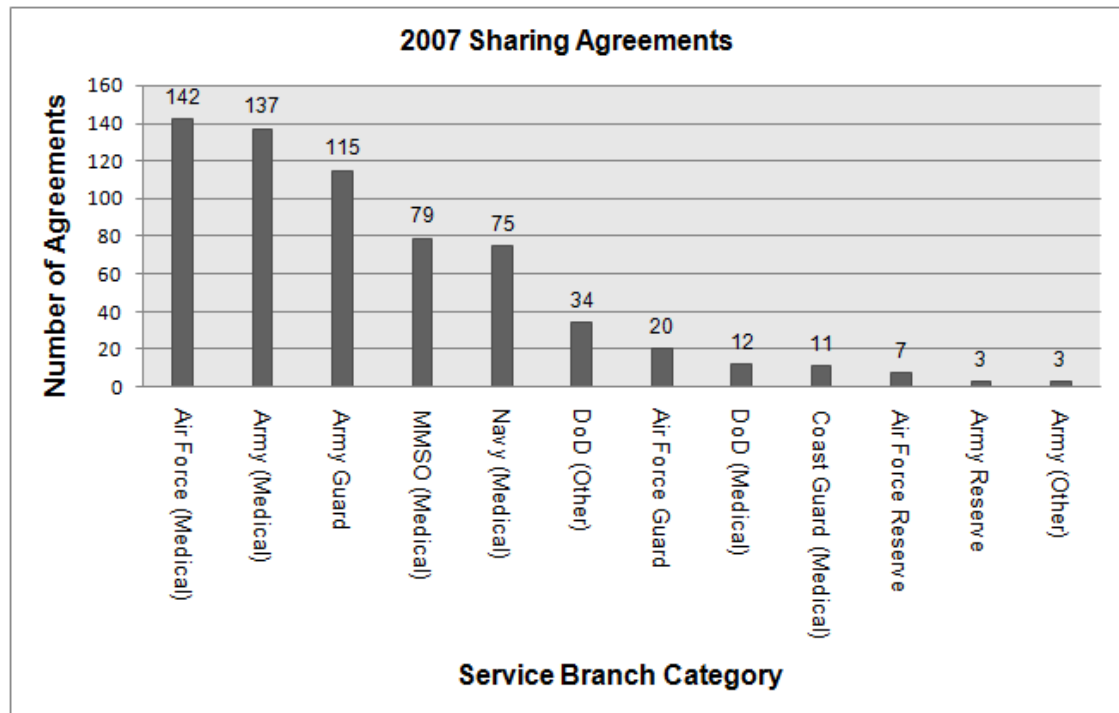


Chart 1. Active sharing agreements as of November 2007

Chart 2 compares the number of sharing agreements by VISN and Service Branch. VISN 3 has a significantly greater number of sharing agreements than the other VISNs but closer review shows that 84 of its 108 sharing agreements are with one organization, the New York Army National Guard, and may only be active when the various National Guard units are mobilized to deploy. VISN 21 has the second greatest number of Resource Sharing agreements with 23 agreements between Pacific Island Healthcare System and Tripler Army Medical Center (TAMC). This is no surprise as these two closely located organizations have long been identified as having one of the most integrated healthcare systems.

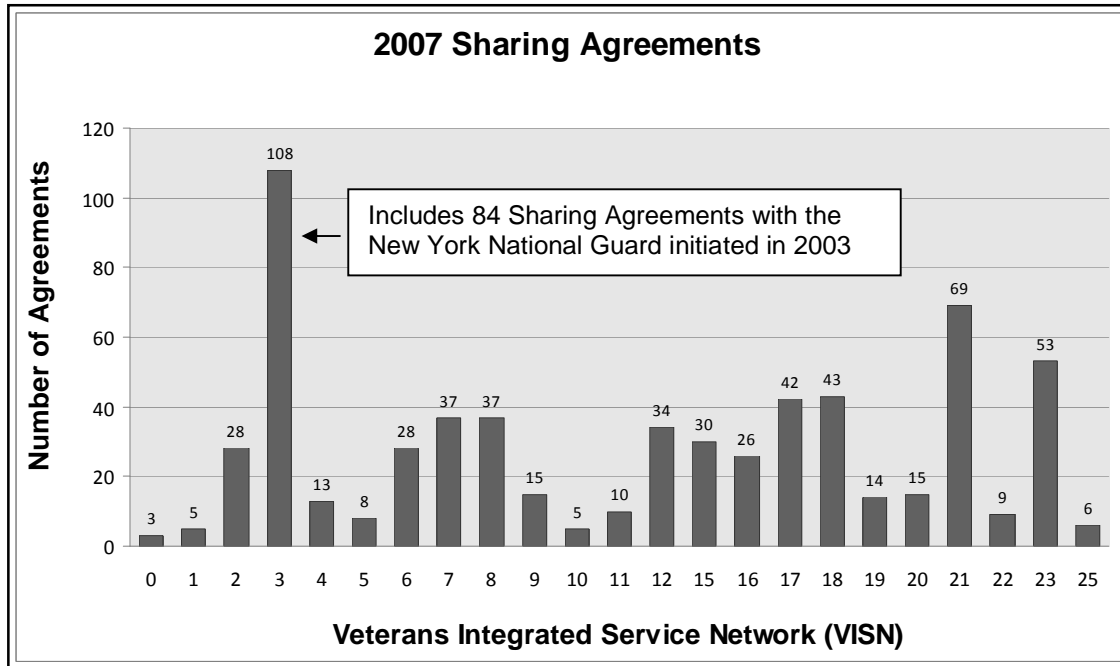


Chart 2. Total active Resource Sharing Agreements by VISN

The result of grouping the 638 individual resource sharing agreements by major category of service provided is shown in Chart 3. Again, while the total number of agreements is initially impressive, most of the resource sharing agreements are for administrative and support services (i.e. Laundry services and Housekeeping) and may not directly contribute to improving healthcare. Another factor potentially inflating the success of the resource sharing program is the relatively high number of agreements for Dental Services between the VA and the Military Medical Support Office (MMSO). MMSO was established to serve as the centralized Tri-Service point of contact for medical and dental healthcare support for DoD personnel in remote locations.⁴³ While these agreements meet the intent of the Resource Sharing program, based on the limited number of DoD personnel in remote locations it is presumed that the utilization rates and true cost avoidance produced by the agreements is relatively low.

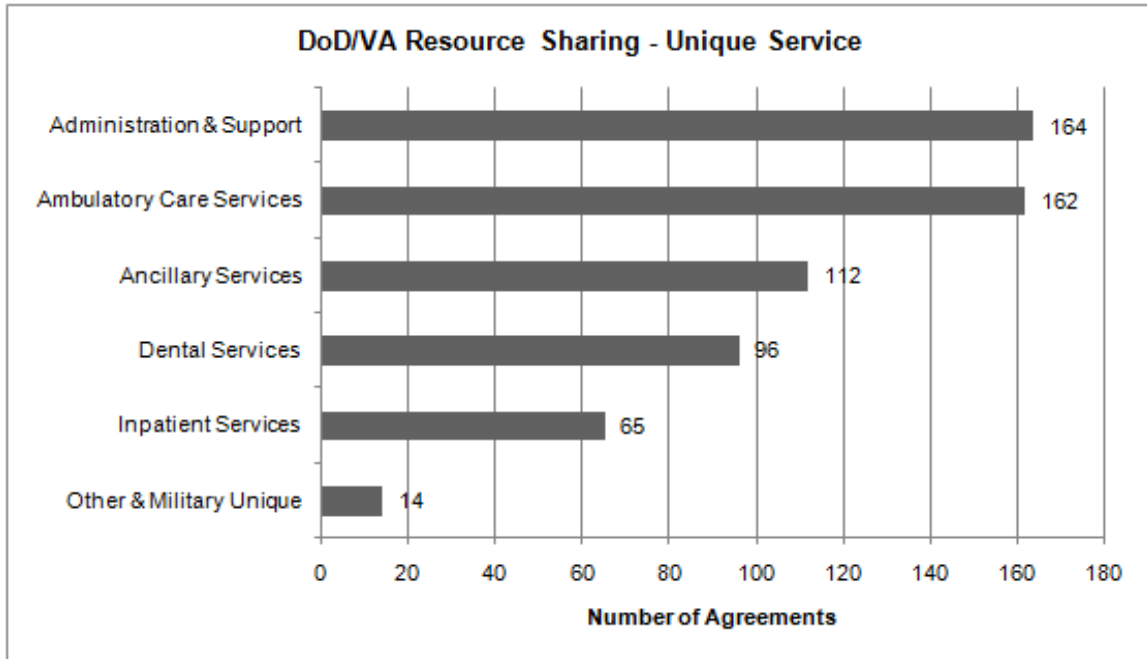


Chart 3. Top ten unique services FY 2007 Sharing Program

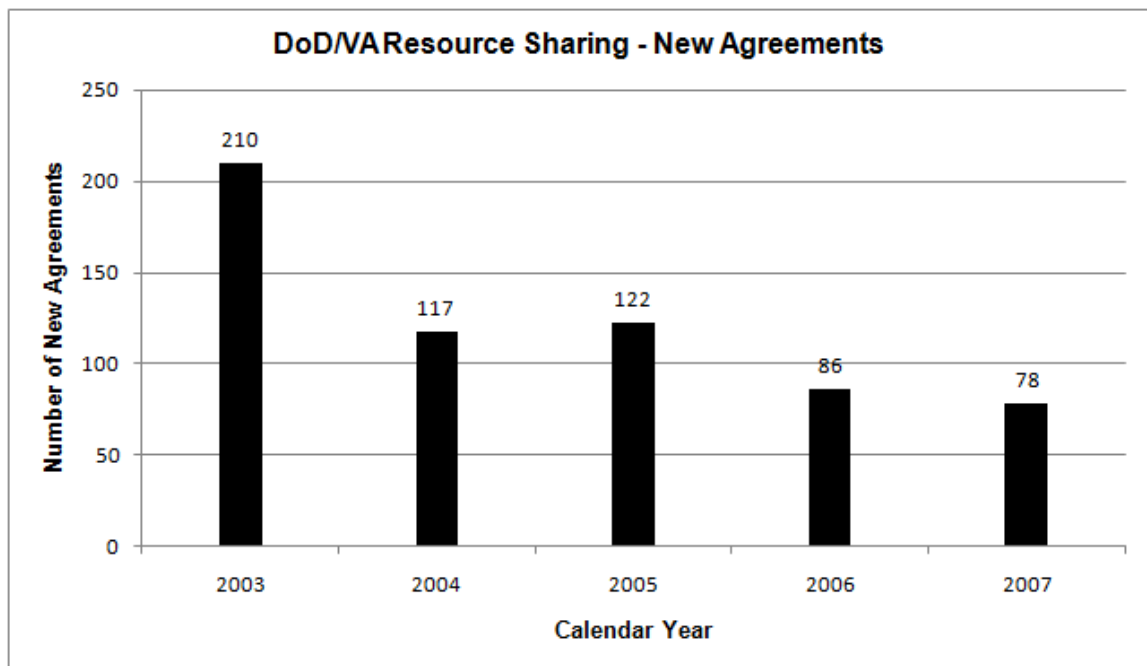


Chart 4. DoD/VA Resource Sharing – New Agreements by Calendar Year

Chart 4 illustrates that despite the renewed interest in DoD/VA collaboration, the number of new resource sharing agreements has been slightly declining for the last four years. The

significant number of resource sharing agreements in Calendar Year (CY) 2003 can be explained by the healthcare requirements generated by National Guard units mobilizing for deployment or other homeland defense missions. In 2003, the New York Army National Guard initiated seven master agreements (1998-FRS-0222A thru 1998-FRS-0229A) with a total of 84 sub-agreements with multiple local area VAMCs. The steady decline in the number of new agreements from 2003 to 2007 may indicate that both the DoD and VA healthcare system are optimized and have very little new excess capacity. While this is possible, it is more likely that the inherent barriers to sharing continue to impede the number of new resource sharing agreement.

As stated earlier, the Resource Sharing Program's goal is to ensure the optimum use of DoD and VA medical treatment facilities (MTFs) resources and services within the same geographic area to improve access to cost effective, quality healthcare for both DoD and VA beneficiaries. Most of the resources sharing agreements are based on the utilization of excess healthcare capacity. The "provider" in the agreement is the organization with the excess capacity and the "receiver" is the organization with unmet demand. It is possible for both Departments to be identified as the provider if they exchange services in a mutually beneficial manner. As shown in Chart 5, in approximately 70 percent of the total agreements the VA is the provider of the service and DoD is the receiver. The fact that the VA is the provider in the majority of the sharing agreements is not unanticipated given the larger size of the VA healthcare system when compared to DoD. It is interesting to note that from CY 2004 to CY 2006 the number of agreements where both DoD and the VA were considered the provider rose by 29 percent. While the number agreements where both the DoD and VA are the provider remains relatively low, it may indicate that both Departments are using innovative methods of exchanging services in attempts to partner more closely.

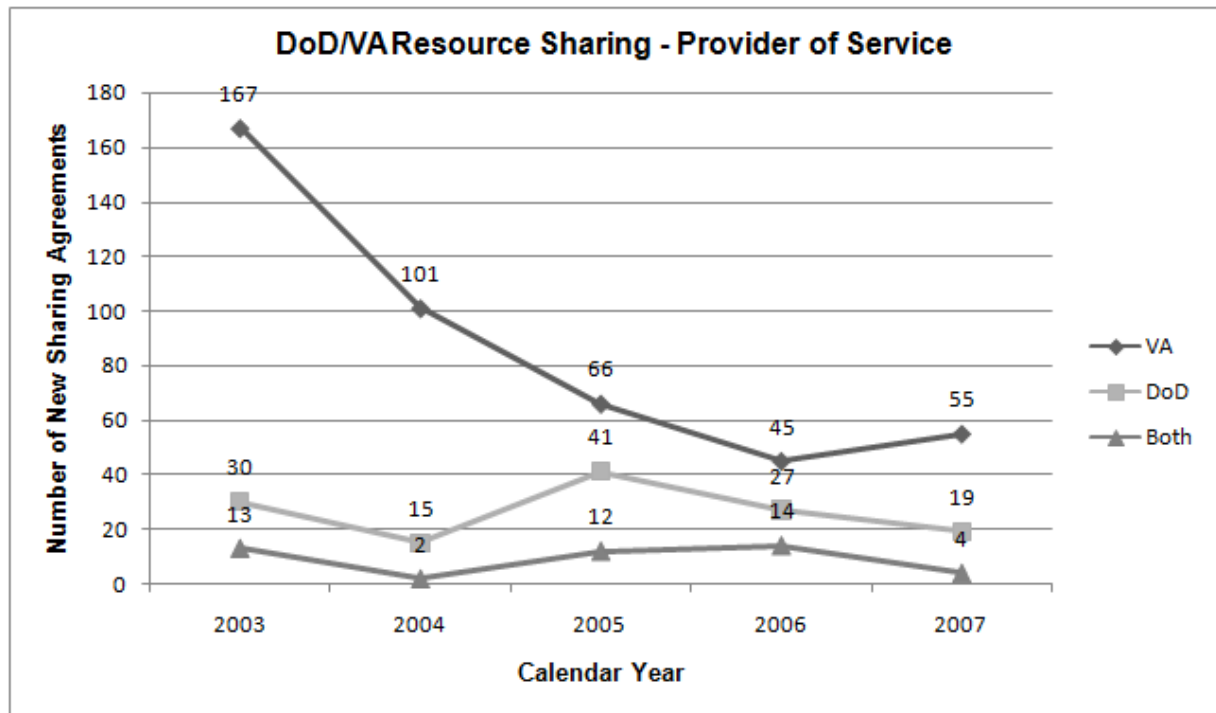


Chart 5. DoD/VA Resource Sharing – New Agreements by Provider of Service

Reimbursement rates have long been a point of contention between the DoD and VA. In the early stages of the Resource Sharing Program there was a proliferation of rate setting mechanisms which introduced complexity in the billing process and called into question the financial efficacy of the agreements. Facilities focused their attention on the negotiation of reimbursement rates instead of collaborating together.⁴⁴ The current business rules for resource sharing set reimbursement rates at the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC) less 10 percent for all clinical services and specialty programs. CHAMPUS is a federally-funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.⁴⁵ Inpatient billing and ancillary and non-patient services are both subject to local negotiation.⁴⁶ Although less popular, sharing agreements can also be bartered or provided at no cost to the other Department.

Chart 6 shows that in CY 2003, the majority of the sharing agreements were for outpatient services reimbursed at the CMAC rate less 10 percent. Although the intent of the Resource Sharing Program is not to produce additional revenue at the expense of the other Department, in CY 2004 the VA and DoD may have realized that it would be more lucrative

for their organization to focus on new agreements for inpatient, ancillary services, or other non-patient services reimbursed at the fee for service rates. This could explain the 36 percent increase in fee for service agreements from CY 2003 to CY 2004. The dramatic swing in reimbursement methods from CY 2003 to CY 2004 combined with the fact that a significant percentage of the current agreements are reimbursed on a fee for service basis highlights the “win-lose” attitude prevalent among the Departments. The “win-lose” attitude is one of the natural barriers to resource sharing.

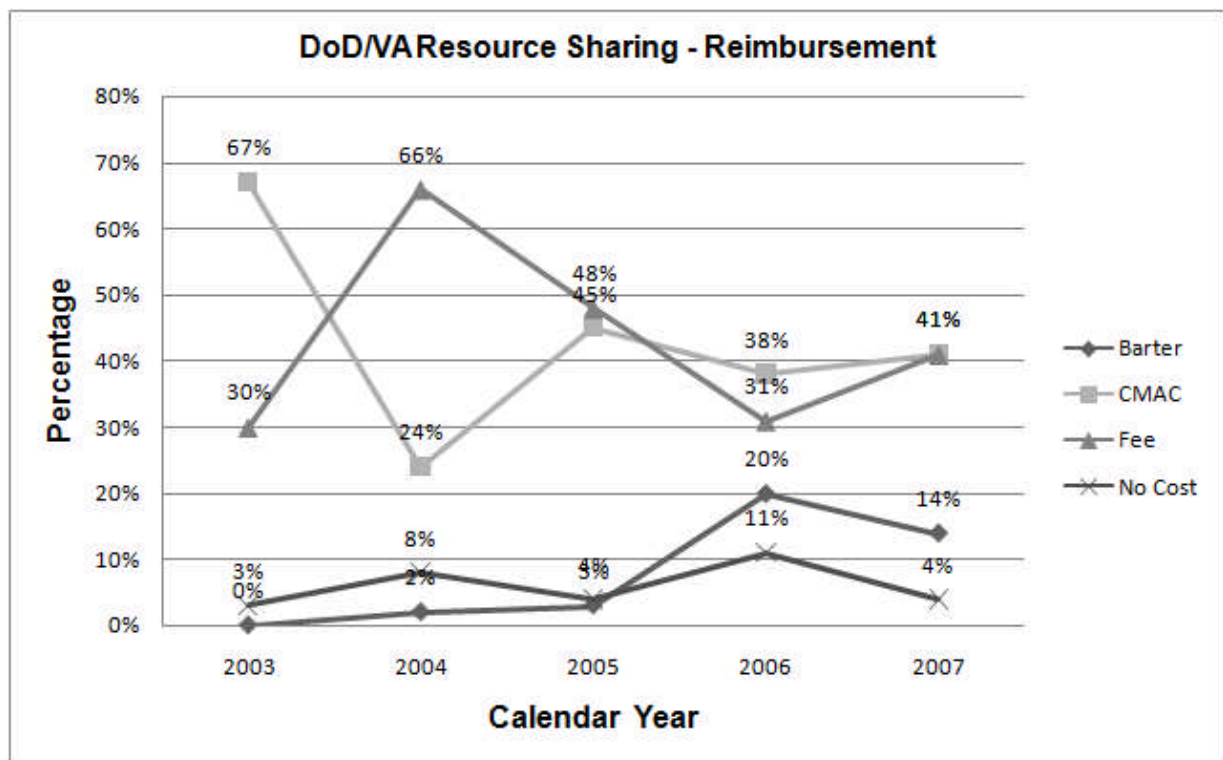


Chart 6. DoD/VA Resource Sharing – Reimbursement Method

Although the Resource Sharing Program has improved healthcare for both DoD and VA beneficiaries, its continued success needs consistent effort and requires both Departments to take proactive roles. The inherent barrier to DoD/VA resource sharing program is best captured by Dr. J. Jarrett Clinton, a previous acting Assistant Secretary of Defense for Health Affairs when he stated, “When viewed as a mutually beneficial relationship, the two Departments focus on a win-win relationship of agreement that benefits the government and both Department's beneficiaries.” The salient point is, if the agreement is considered to be mutually beneficial, then resource sharing works. If the potential

agreement is perceived to have a winner and a loser, then resource sharing becomes much more difficult or does not happen at all unless directed to do it by legislative mandate. Single governance would remove this barrier. While the joint executive councils and working groups previously discussed are temporarily increasing collaboration, this approach is not strategic in nature. The proliferation of the number of DoD/VA councils and groups leads one to the conclusion the next logical step is a system merger.

RATIONALE FOR SINGLE GOVERNANCE – WHY NOW?

Malcolm Gladwell describes the phrase “Tipping Point” in his bestselling book, The Tipping Point: How Little Things Can Make a Big Difference, as a term given to that specific time in an epidemic when a virus reaches critical mass. “It’s the boiling point...the moment on the graph when the line starts to shoot straight upwards.”⁴⁷ The urgent requirement to increase collaboration between the DoD and VA healthcare systems to meet the overwhelming needs of service members returning from war, combined with legislative mandates, and the public demand for seamless care for service members, veterans, and their families all clearly indicate the tipping point for significant change in the delivery of DoD/VA healthcare has been reached.

What makes the single governance argument more relevant now is the national attention given to the increasing cost, duplicate services, and difficulties experienced by OEF/OIF veterans transitioning from the DoD to the VA healthcare system. As of March 2007, Veterans Healthcare Administration (VHA) coordinated the transfer of over 6,800 severely injured or ill active duty service members and veterans from DoD to the VA.⁴⁸ As of the first half of FY 2007, approximately 263,900 returning veterans have sought care from VA medical centers and clinics.⁴⁹ The Congressional Budget Office (CBO) estimates the total cost to provide health care to OEF/OIF veterans with service connected conditions to be between \$7 and \$9 billion over the next ten years.

Single governance would negate the need for continued and unproductive legislative mandates. Instead, it would inherently merge resources, centralize administration and payor processes, optimize its vast resources into a single integrated healthcare delivery system, and no longer require beneficiaries to navigate between two bureaucratic health benefit plans. Examples of legislative involvement includes language in the recent NDAA which

requires a comprehensive DoD/VA policy to address traumatic brain injury (TBI), military eye injuries, post-traumatic stress disorder (PTSD) and other mental health conditions, as well as creating centers of excellence focused on these conditions. Other sections of the FY 2008 NDAA require the DoD and VA to jointly develop an electronic medical record, along with developing and implementing a comprehensive policy on the care and management of members of the Armed Forces (members) who are undergoing medical treatment, recuperation, or therapy, or are in medical hold or holdover status. The Veterans Program Enhancement Act (P.L. 105-368) of 1998 entitles OEF/OIF veterans with health conditions that are potentially related to combat service with enhanced access to the VA healthcare system for five years post separation date. House Resolution (H.R.) 612, Returning Service Member VA Healthcare Insurance Act of 2007, extended the period of eligibility from two to five years.⁵⁰

Single Governance Will Improve Cost, Quality, and Access

Cost, quality and access are commonly referred to as the “iron triangle” of healthcare systems.⁵¹ The goal is to create a system that increases quality and access at a reduced cost. Merging DoD/VA healthcare systems to create a single governance structure will require “best of breed” competitions for information management and technology, personnel, budget and financial management, logistics, and clinical systems and will improve access and quality while reducing healthcare cost.

- Costs – The success of the national sharing initiatives, specifically the joint purchase of medical supply and pharmaceuticals, demonstrates that a single governance structure can produce real savings. Consolidating the majority of the leadership, management and other positions of the ASD(HA), TMA, VHA, DoD/VA coordination offices, Seamless Transition Office, and the majority of the lower level coordination offices will reduce human resources cost and thereby reduce the total cost of health care. In May 2006, the Center for Naval Analysis (CNA) conducted a very relevant study of the cost implications of a creating unified military medical command. The CNA estimated that merging the current military medical system into a joint organization would produce an annual savings projected to be between \$282 and \$417 million depending on the option selected.⁵² Some of the projected personnel cost saving may be reduced by current DoD medical personnel migrating to VA’s system of employment benefits. Single governance would also resolve inconsistent reimbursement and budgeting policies, and the burdensome

agreement approval processes. The cost savings/avoidance currently experienced at the North Chicago VAMC – Naval Clinic Great Lakes single governance project clearly demonstrates the potential. Single governance allowed for expedited creation of a joint mental health service which is projected to produce an annual savings of \$1,000,000. The joint Navy Blood Bank will produce a cost avoidance of \$850K to \$3.1M and the joint ICU/CCU operation has reduced total costs by \$920,000.⁵³

- Quality – One medical system, specifically one electronic health record, will enhance the continuity of medical care for OEF/OIF veterans as they leave DoD and enter VA healthcare. The existing incompatible medical computer systems limit the exchange of patient health information which negatively affects the quality of healthcare. The lack of a standard electronic medical record is a significant quality of care issue and is discussed in more detail below. Single governance structure would improve the quality of care by ensuring both Departments have access to the state of the art prosthetic and other medical devices. Similarly, the enhanced sharing of best practices and other clinical initiatives will undoubtedly improve the quality of healthcare.

- Access – Access to care for all categories of beneficiaries will improve in a single governance system. VA beneficiaries would have access to DoD facilities and the well established and robust network of TRICARE healthcare providers. DoD beneficiaries would have access to the much larger and geographically dispersed VA healthcare system including access to long term rehabilitation care, and other mainstays of the VA healthcare system. It is also anticipated that both DoD and VA beneficiaries would gain access to medical facilities closer to home.

Single Governance Would Eliminate Redundant Clinical and Administrative System

There have been many attempts to consolidate the DoD/VA non-clinical and education systems. The best example is Department of Defense-Department of Veterans Health Resources Improvement Act of 2001 (H.R. 2667) which called for five demonstration sites where a “unified staffing, compatible software and Graduate Medical Education would be developed and implemented.”⁵⁴ The intent of the legislation was “to force the DoD/VA to consolidate resources.”⁵⁵ While the resolution never became law it does demonstrate the merit of consolidation. Single governance would force the elimination of operating two separate systems for logistics, purchasing supplies and equipment, budgeting/financial

management, quality assurance and leadership structure. Single governance would result in merging the majority of the management positions currently in ASD (HA), TMA, VHA, and the various DoD/VA coordination offices.

Redundant Electronic Health Records (EHR)

Perhaps the most significant case for the proposed merge of healthcare systems is best demonstrated by the difficulty creating a single Electronic Health Record (EHR) for DoD/VA beneficiaries. The VA developed the Veterans Health Information Systems and Technology Architecture program (VistA) electronic health record, while DoD uses a system called the Armed Forces Health Longitudinal Technology Application (AHLTA). Combined, the Departments have spent nine years and over \$1.8 billion dollars developing parallel outpatient EHRs. This issue is so significant that in November 1997, President William J. Clinton called for the two agencies to start developing a “comprehensive, lifelong medical record for each service member” that allows a seamless transition between the DoD and VA, as well as meeting the immediate needs to exchange information, including responding to military or national crises.

Since 1997, there have been at least eleven GAO reports and Congressional testimonies regarding DoD/VA electronic data sharing (See Annex B). Although there has been recent success as evidenced by the development of a Bidirectional Health Information Exchange (BHIE) and the ability to perform an “ad hoc” activity to increase the exchange of health information between DoD and the VA’s polytrauma centers, a fully compatible EHR remains a significant issue.⁵⁶ Part of the reluctance to create a single EHR may be explained by how the systems were developed. While the VA internally developed VistA, the DoD contracted with Science Applications International Corp (SAIC) to develop AHLTA. The contractor’s concern about the potential loss of a significant DoD contract may help explain the merger difficulties.

Redundant Managed Care Contracts

As stated earlier in the background of the two healthcare systems, DoD has developed the TRICARE program which is a very robust network of civilian healthcare providers augmenting the DoD’s direct healthcare system. In an effort to optimize its purchased healthcare system, the VA is currently attempting to develop a similar network of providers and have called the initiative Project HERO. This new program is identical in concept to the

current TRICARE program and single governance would have prevented this from occurring.⁵⁷

Redundant Medical Services/Programs

Dr. Paul Tibbits, Deputy Chief Information Officer for the VA and Dr. Stephen L. Jones, Principal Deputy ASD (HA) developed Figure 3 which best exhibits the similar requirements and inherent redundancies of the VA and DoD health care systems. In efforts to provide the best possible care to wounded warrior, both Departments are creating duplicate medical services and programs. An example of this is the Center for the Intrepid, a 65,000 square foot rehabilitation center at Brooke Army Medical Center in San Antonio, Texas. The Army Medical Department is now running a state of the art rehabilitation facility when rehabilitation is a core competency of the Veterans Healthcare Administration. There are other examples of redundant Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) Centers of Excellence in both the DoD and VA healthcare systems.

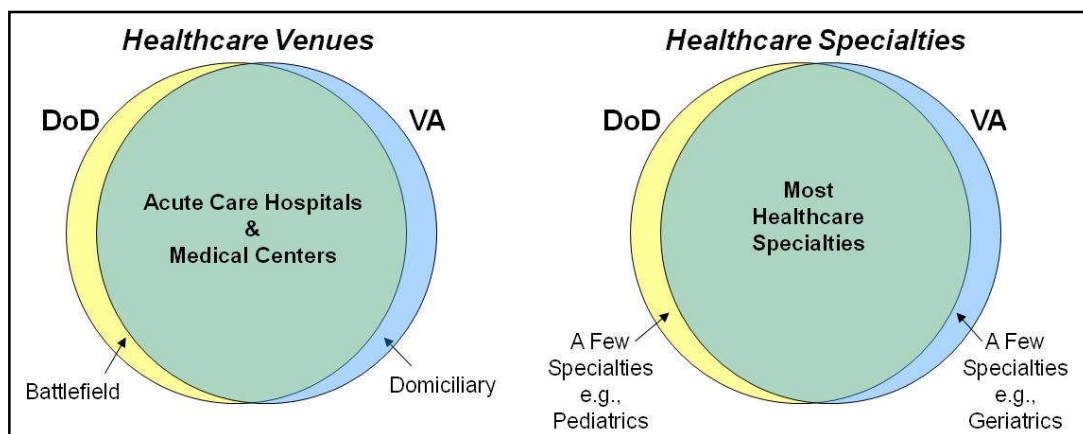


Figure 3. Comparison of DoD and VA Healthcare Venues and Specialties

Redundant Graduate Medical Education (GME) Programs

All branches of the DoD medical services have their own GME programs while the VHA is the nation's largest provider of graduate medical education and a major contributor to medical and scientific research. The VA partners with 107 medical schools and 2,000 colleges or universities. Although the VA does not currently operate a GME program, merging the DoD's GME programs into the VA's established partnerships with civilian institutions to create a Federal GME program would potentially enhance military GME by

giving them access to medical training at the VA's polytrauma centers and extensive network of civilian institutions currently working with the VA.

RESISTANCE TO SINGLE GOVERNANCE

While the conceptual merit of single DoD/VA healthcare governance structure is generally recognized, the resistance to the concept focuses on the following main themes: losing control, therefore accountability, over legal responsibilities to provide healthcare; the current DoD/VA resource sharing process is producing results and is sufficient; the healthcare systems are just too different and complex to merge; and concern that a merger will negatively affect the status and ability of either organization to execute its core mission.

Losing Purview of Their Legal Responsibility

Any single governance structure would require Congressional action to create a new Federal entity. This is based on current law which holds both Secretaries legally responsible for their respective Departments; they currently cannot transfer their respective responsibilities into a shared control arrangement.⁵⁸

The VA's primary concern is that some form of merger will result in losing the ability to influence how healthcare is provided to their beneficiaries. Before agreeing to a system merger, the VA would have to assume that the VA would retain control of enough assets to guarantee the ability to meet its responsibilities to veterans. Merging the VHA with the MHS generates politically significant concern among the Veteran Service Organizations (VSOs) that medical care for veterans would "lose out" to medical care to DoD beneficiaries.

The fundamental concern voiced by the DoD, which can be found in Congressional testimony dating as far back as May 2001, is that some form of single or joint governance will negatively affect military readiness. Summarizing DoD's position, if the two healthcare systems merged, the DoD's ability to respond to a contingency mission would be limited.⁵⁹ This is supported by an excerpt of a statement made by Major General (Dr.) Lee P. Rogers, U.S. Air Force, former Commander, 59th Medical Wing, Lackland Air Force Base testifying before a hearing before the Military Personnel Subcommittee of the Committee of the Armed Service in the House of Representatives in May 2001. The hearing concerned lessons learned from TRICARE Managed Care Support Contracts, but included testimony about

DoD/VA sharing. In response to a question about how DoD/VA sharing is affecting readiness General Rogers stated, "The one concern I would have in relationship to readiness is, as we move closer, we can improve. But if we then make business decisions and decrease our inherent capability to respond to the contingencies, then we have hurt both systems."⁶⁰

During the same hearing, Representative McHugh stated that he often hears from both DoD and VA officials at lower levels that their concern about merging the two systems is about the erosion of the core mission, "Well, you know, integration causes problems, and our primary mission is readiness of our troops. And we have to make sure that that core mission is protected, and we are afraid that that might be eroded through significant integration."⁶¹ Mr. Stephen Backhus, former Director, Veterans' Affairs and Military Health Care Issues, General Accountability Office (GAO), best summarized the issue when he stated "The issue of readiness, I think, comes into play depending on what level of integration we are talking about. If people view this as a merger of the two systems, then there becomes significant concern over who is going to be in charge. And, obviously, there is this need to maintain the military capability first and foremost, and they need to be very certain about that."⁶²

While maintaining readiness is a compelling argument, it is not quite accurate. As long as combat related medical training is provided then the two healthcare systems can be merged without affecting the military physicians' ability to perform their wartime mission. Gaining routine access to a more medically diverse beneficiary population, the VA's inner city hospitals, and multiple polytrauma centers may actually enhance military readiness.

Belief that the Current Methodology of Resource Sharing Agreements is Sufficient

While the efficacy of the resource sharing program remains difficult to define, multiple GAO reports found that both Departments have recently expanded sharing of medical information, improved the disability and compensation processes, and established joint innovative programs for PTSD/TBI and other medical initiatives. A GAO study published in March 2006 found that the VA and DoD are creating mechanisms that support the potential to increase collaboration, sharing, and the coordination of management and oversight of healthcare resources and services.⁶³ Another GAO study in October 2007 found the DoD and VA continue to made significant progress in the exchange of healthcare information which enhances the care provided to service members' transition to the VA's medical

system. Specifically mentioned was the recent progress allowing the VA's polytrauma centers to query the DoD's healthcare information systems which enhanced the health care for wounded warriors. While multiple GAO reports and other studies conducted in the last five years did find unprecedented amounts of collaboration, all of the same reports also pointed out that there is more work to be done. A recent GAO study released in March 2008 noted improvements in collaboration but also found a lack of measurement tools to evaluate the joint effort.⁶⁴

The Healthcare Systems Are Too Different to Merge

As part of Cabinet level Departments, the two healthcare systems have significantly different human resource, finance/budget, information management/information technology, administrative systems, and organizational cultures. Although the DoD and VA healthcare systems are similarly motivated organizations and share the goal of providing as much service as possible to their beneficiaries with their allocated budgets, each healthcare system offers unique services/benefit packages designed to meet the needs of their diverse beneficiary populations. Although the increasing number of women as OEF/OIF eligible veterans are changing the VA demographics, the traditional beneficiary population of the DoD tends to be younger and healthier, with more women and children, while the typical VA beneficiary is older, male, and may have multiple and chronic health issues.

Additionally, the DoD has developed an extensive network of civilian healthcare providers (TRICARE) augmenting its direct healthcare system. In a 2005 TRICARE conference presentation, the DoD healthcare system was described as an "open system" where health services are provided at DoD facilities in conjunction with a large private and public sector network. The DoD must work with TRICARE contractors to ensure the appropriate provision of care is provided throughout a region with healthcare benefits extended to active duty and family members, retirees and their family members. This contrasts with the VA's focus on taking care of the veteran using its internal healthcare network. Unlike the DoD, the VA health system is considered to be a "closed system" where nearly all health services are provided "within the walls" of the VA facility. While not necessarily as strong an argument, the disparity between the beneficiary demographics, the diversity in types of services provided, the differences in enterprise-wide culture, and the nuances in the operations of the two healthcare systems may support the thought that the systems are simply too difficult to effectively merge.

Veterans Affairs May Lose Cabinet Level Status

Losing direct authority and responsibility for one of its three major components may place the VA at risk for losing cabinet level status. Proponents who successfully supported Cabinet-level status for the Veterans Administration long stressed that the VA was the largest independent Federal agency in terms of budget and was second only to the Department of Defense in number of employees. Because one-third of the U.S. population was eligible for veterans benefits, proponents argued, the agency responsible should be represented by a Cabinet secretary having direct access to the president.⁶⁵ Representative G. V. (Sonny) Montgomery, Democrat of Mississippi, and former chairman of the House Veterans Affairs Committee, said that before the VA achieved cabinet level status he felt the VA was run by the Office of Management and Budget.⁶⁶

On October 25, 1988, President Reagan signed legislation creating a new Federal Cabinet-level Department of Veterans Affairs to replace the Veterans Administration effective March 15, 1989.⁶⁷ "There is no better time or better way to salute those valiant men and women than to announce today my decision to support the creation of a Cabinet-level Department of Veterans Affairs," Mr. Reagan said. "This is a personal decision that I have thought about for some time," he said. "Veterans have always had a strong voice in our government. It's time to give them the recognition they so rightly deserve."⁶⁸ Once reorganized, the Department included three main elements: the Veterans Health Administration; the Veterans Benefits Administration; and the National Cemetery System.

Lingering Perception that VA Health Care is Inferior

Until fairly recently, the quality of healthcare provided at VA hospitals was generally perceived to be inferior to other health systems. The lingering perception, fueled by popular culture and publicity of recent reports where substandard care resulted in the death of VA beneficiaries at the VA center in Marion, IL, may explain some of the DoD's reluctance to create a single healthcare system. While the perception is noted, it is also baseless. Due to extensive system re-engineering in the mid-1990s, the VA has dramatically improved its healthcare system as verified by National Committee for Quality Assurance (NCQA) which recently ranked the VHA among the nation's top healthcare systems. A recent CBO study found that the VA's rating for quality of care and customer satisfaction has improved. The transformation has been so successful it is the subject of a Harvard Business School

Business Case and is documented in a book, Best Care Anywhere: Why VA Health Care is Better Than Yours.⁶⁹

Veterans Service Organizations (VSOs)

The VSOs have been very influential in VA affairs and will actively participate in any process potentially affecting their access to healthcare. The VSOs were very instrumental in determining the success or failure of the VA's Capital Asset Realignment for Enhanced Services (CARES) program which is a system-wide process to prepare the Veterans Administration (VA) for meeting the current and future health care needs of veterans in modern health care facilities.⁷⁰ DoD also experienced significant resistance from its retiree groups when it moved MEDICARE eligible beneficiaries out of the TRICARE system. The change was eventually accepted after the TRICARE For Life (TFL) program was created. Both the VSO's involvement in the CARES program and DoD retiree's resistance to being pushed out of the TRICARE program demonstrates the influence of veterans and military retiree groups on any attempt to reorganize their healthcare.

DESPITE RESISTANCE, CHANGE ON THIS SCALE HAS HAPPENED

Obviously, merging the DoD/VA healthcare systems into a single governance structure is a massively complex issue even at the local level. There are multiple second and third order effects but they should not rule out efforts to consider the concept's merits. Despite initial resistance, change in the Federal Government on this scale has recently happened as evidenced by the creation of the Department of Homeland Security (DHS) on November 25, 2002. The DHS was established by the Homeland Security Act of 2002 and the intent was to consolidate multiple U.S. executive branch organizations related to homeland security into a single Cabinet agency. The 22-agency reorganization began on March 1, 2003, when Federal agencies such as the Federal Emergency Management Agency (FEMA), the Secret Service, U.S. Customs, and Immigration and Naturalization Service (INS) were brought "under one roof."⁷¹

An example of interdepartmental transfer of a healthcare program is the Uniformed Services Family Healthcare Plan. In 1981 Congress enacted the Omnibus Reconciliation Act that designated certain former U.S. Public Health facilities as Uniformed Services Treatment Facilities (USTFs) to provide health care for Uniformed Services beneficiaries. In 1982,

responsibility for overseeing the USTF Program was transferred from the Department of Health and Human Services (HHS) to the DoD. In 1993, the USTFs were reorganized by DoD into the Uniformed Services Family Health Plan, the first DoD-sponsored, full-risk managed health care plan, and the first to serve military beneficiaries ages 65 and over. In the same year, CHAMPUS, the national military health care program, was reorganized into TRICARE. TRICARE offers three options, including Prime, which is the managed care option. The US Family Health Plan was designated an authorized TRICARE Prime provider. Following the success of the Plan, Congress made it a permanent part of the military health care system in 1997.⁷²

DoD Internal Change

Large scale change has also recently happened internal to the DoD healthcare system. As part of an initiative to explore the value and effectiveness of a unified medical command, Deputy Secretary of Defense Gordon England established the Joint Task Force National Capital Region Medical Command (JTF CAPMED) in September 2007. This office, projected to be led by a three-star military medical officer, is responsible for the entire integration of Walter Reed Army Medical Center and the National Naval Medical Center to create the Walter Reed National Military Medical Center (WRNMC). WRNMC is to be established on the military campus at Bethesda, Maryland. The DoD envisions this new center to be the premier flagship for military medicine, with the former Assistant Secretary of Defense (Health Affairs) having remarked that, "it will rival Mayo Clinic, Johns Hopkins, and the other great medical institutions of the world." In addition to the overall integration, the Commander will be responsible for the integration of the Army, Navy and Air force assets delivery of health care services in the entire National Capital Region.⁷³ The creation of JTF CAPMED demonstrates that significant change is possible in the DoD Military Health System (MHS).

Another recent example of multi-service merger can be found in San Antonio, Texas. As a result of the DoD directed base realignments and closures (BRAC) proceeding, U.S. Air Force and Army medical assets are merging together to form one medical system. BRAC 2005 recommended the consolidation of the U.S. Air Force's Wilford Hall Medical Center (WHMC) and Brooke Army Medical Center (BAMC) in San Antonio into one medical region with two integrated campuses known as San Antonio Military Medical Center (SAMMC). Brooke Army Medical Center will become the inpatient tertiary care center providing all inpatient care as well as all trauma and emergency medical care. The facility will be known

as SAMMC - North. Wilford Hall Medical Center will be converted into a large ambulatory care center, SAMMC - South.⁷⁴

While the creation of JTF CAPMED and SAAMC are significant achievements and indicators of real progress, by not including VA assets in these reorganization efforts both Departments missed an opportunity for even more effective change.

Initial Attempt at Forming a DoD/VA Single Governance Structure

The most comprehensive DoD/VA effort to create a single governance model to date is ongoing in the Chicago, IL area and involves the North Chicago Veterans Medical Center (NCVAMC) and Naval Health Clinic - Great Lakes. Although there are other examples of DoD/VA joint ventures where the facility was renamed as a Federal Medical center, the Federal Health Care Facility (FHCF) North Chicago is the first attempt to create a single governance structure where one Department has a single line of authority over assets from both Departments.

The NCVAMC and the Naval Hospital Great Lakes are located in the North Chicago area and are located approximately 1.5 miles apart. Although closely located, the two facilities have operated as independent facilities separated serving VA and DOD beneficiaries for decades. A 1998 GAO study recommended the VA close one of its facilities in Chicago. In 1999, VISN 12 discontinued all inpatient services at the NCVAMC and in June 2001 the facility was as under consideration for closure as part of the VA's Capital Asset Realignment for Enhanced Services (CARES) program. In 1995, the U.S. Navy consolidated its training program and as a result the beneficiary population decreased and the facility was subject to the Base Realignment and Closure Commission in 2005. Additionally, the hospital experienced significant, Joint Commission (JCAHO) identified facility concerns requiring approximately \$8 million to correct.

With both facilities at risk for closure or significant downsizing, U.S. Representative Mark Kirk (R-Ill.), spearheaded an ambitious plan that would combine the two aging facilities into a new Federal Health Care Facility (FHCF) for both DoD and VA beneficiaries. At the direction of senior leadership, the VA and the Navy established a joint task force consisting of six workgroups (human resources, leadership, finance/budget, information management/

information technology, clinical, and administration) to resolve the myriad of issues created by the initial fully integrated unified governance structure.

In September 2004, the Health Executive Council (HEC) directed the VA/Navy Task Force to develop a governance model for the new Federal facility. The joint task force recommended a governance structure using a single line of authority overseen by a board of directors. The HEC approved the recommendation in May 2005 and on 15 October 2005 the ASD (HA) and the Deputy Secretary, Department of Veterans Affairs signed a Memorandum of Agreement on 17 October 2005.⁷⁵

On 1 May 2006, attorneys from the VA, Navy and DoD Offices of General Counsel determined that the governance structure described in the 17 Oct 2005 MOA would require Congressional approval to be implemented because the MOA may have exceeded existing legal authority to accomplish the objective of a single integrated line of authority. Legal counsel found that as both Secretaries are legally responsible for their respective Departments, they cannot transfer their respective responsibilities into a shared control arrangement.

As a result of the legal opinion, a hybrid governance model was adopted with the VA Director and a Navy Captain (O6) as the deputy director. DoD's concern about losing readiness oversight and the VA's concerns about maintaining its ability to provide dedicated care for Veterans were addressed by establishing an Advisory Board and giving both Departments direct access to local leadership (see Figure 2).

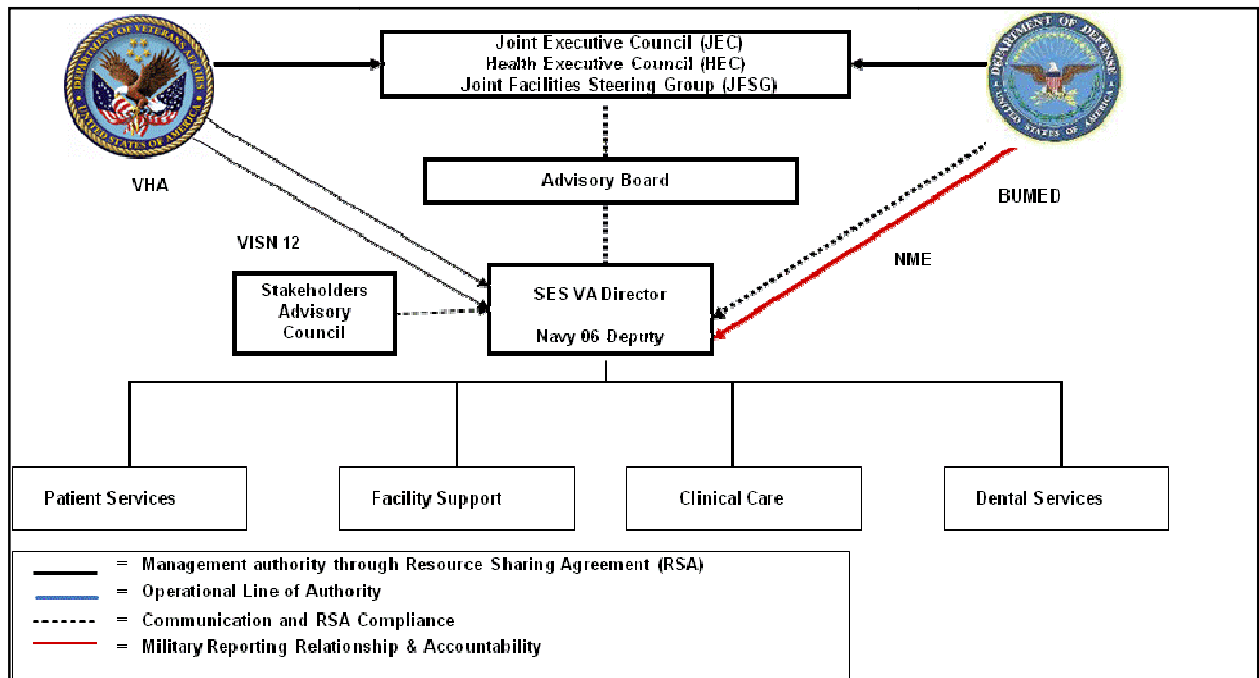


Figure 2. Hybrid single governance model

The benefits and challenges of the above governance model are listed below:

Benefits:

- 38 U.S.C. 8111 and 10 U.S.C. 1104 provide sufficient authority to initiate the project.
- Maintains integrity of appropriate parent Department's oversight and responsibility.
- Focus is on beneficiaries; services are transparent to the patient and provider
- Retains a local integrated management structure for all day-to-day operations.
- Reduces redundancies in management and delivery of healthcare services at the FHCF.
- Provides for a single chain of command, one medical staff and one standard of patient care.

Challenges:

- Requires significant level of cooperation and horizontal communication efforts between both Departments' organizations to support the system into the future
- Crosses cultural borders that place personnel under another Department's authority for daily functions
- Acquisition, budgeting, human resource, medical staff, IM/IT, etc., will require support, commitment, flexibility and leadership from both organizations to develop new processes
- Requires modifications of existing budgeting process and funding methodology for shared services
- Requires continued negotiation regarding development of the Executive Sharing Agreement.

Although the proposed governance structure was determined to be outside of the scope of current public law, the fact that HEC approved the initial proposal demonstrated the apparent merit of the single governance concept.

OPTIONS FOR SINGLE GOVERNANCE STRUCTURES

For the purposes of this paper, single DoD/VA governance options include: (1) merging existing DoD and VA healthcare systems to create a “Federal Healthcare Command” and position it under responsibility of the Secretary of Defense; (2) merging existing DoD and VA healthcare systems to create a “Military and Veteran (MilVet) Healthcare System” and place under responsibility of the Secretary of the Veterans Affairs; and (3) merge and create a “Federal Military Healthcare Administration” and position it under the Department of Health and Human Services (HHS).

Each option requires modification of existing public laws (10 U.S.C. and 38 U.S.C.) allowing for a single funding stream and one agency to assume responsibility for the provision of healthcare to both DoD and VA beneficiaries. A standard eligibility system merging TRICARE beneficiary categories with the VA’s Priority Groups for access to health care would need to be developed. Finally, any merger will also require “best of breed” competitions to select the best IM/IT, personnel, budget/financial, clinical systems, and logistics system for the new organization.

When comparing the options, simple evaluation criteria considered are: (1) system adaptation – the option requiring the least system adaptation is best; (2) concern resolution – the option which best resolves each Departments’ concerns is best; (3) economies of scale and scope; and; (4) viability – the easiest option to execute is best.

The North Chicago – Great Lakes initiative demonstrates that for any reorganization effort to be successful, both DoD and VA’s concerns must be addressed and mitigated. Again, the VA’s primary concern is retaining autonomy and enough assets to meet its responsibility to veterans; the DoD’s concern is maintaining readiness. Ideally, both Departments’ concerns would be given equal weight but given the current environment of heightened national security and the requirements of the Global War on Terrorism (GWOT), all single governance options must resolve DoD’s primary concern of maintaining its readiness posture.

Resolving DoD's Readiness Concern

In December 2004, Program and Budget Decision (PBD) 753 directed the Undersecretary of Defense for Personnel and Readiness USD (P&R) to develop an implementation plan for a Joint Medical Command by the FY 2008 – FY 2013 Program/Budget Review.⁷⁶ In April 2006, The DoD formed a Joint/Unified Medical Command Working Group to consider creating a unified medical command. The working group recommended three options, one of which addressed DoD's readiness concerns by separating the readiness and benefits mission of the DoD healthcare system into two organizations (see Figure 3).

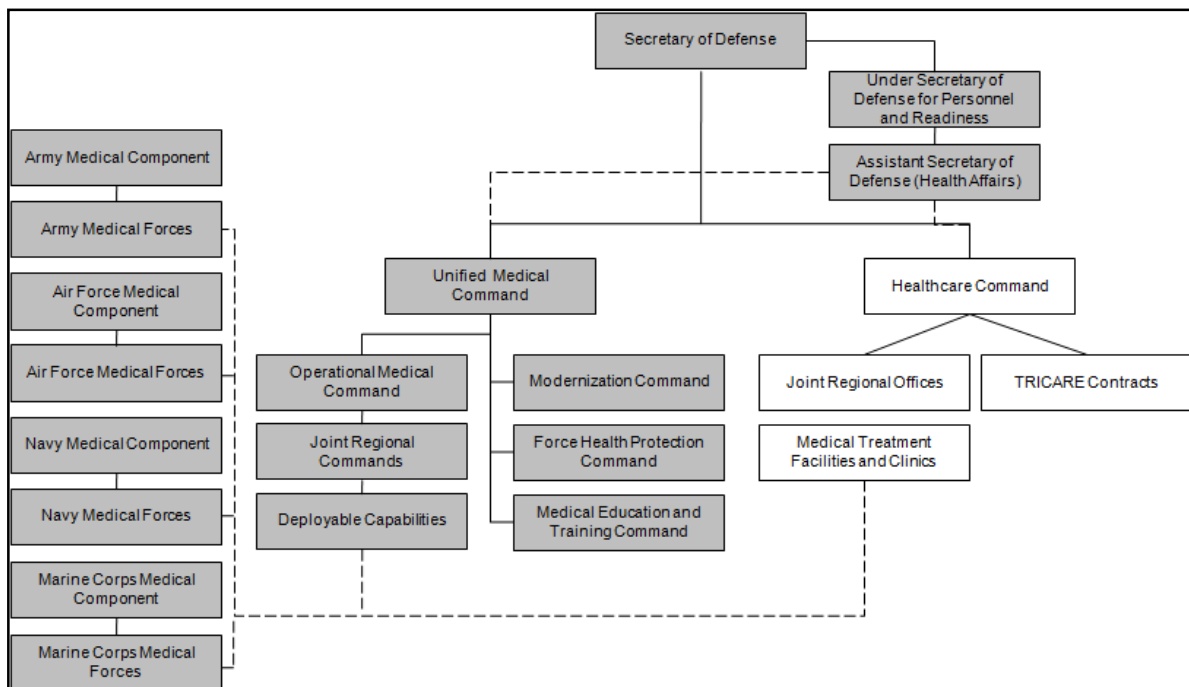


Figure 3. Notional Structure for a Separate Medical Command and Health Command

In the proposed structure, the Medical Command would be responsible for the readiness mission, defined as providing medical support to the Armed Forces during military operations. The Healthcare Command would be responsible for benefits mission which includes providing both direct and purchased healthcare for all beneficiaries.⁷⁷ While this option was not selected, it validates the concept that the readiness and the benefits missions of the DoD healthcare system can conceivably be separated. Using the proposed notional structure described in figure 3 as a model, any option for merging the DoD and VA healthcare systems will only include benefits mission and the assets found in the proposed

Healthcare Command. Again, any proposed unified governance structure would exclude the “go to war” or tactical medical components of the Armed Forces.

Department of Defense Option

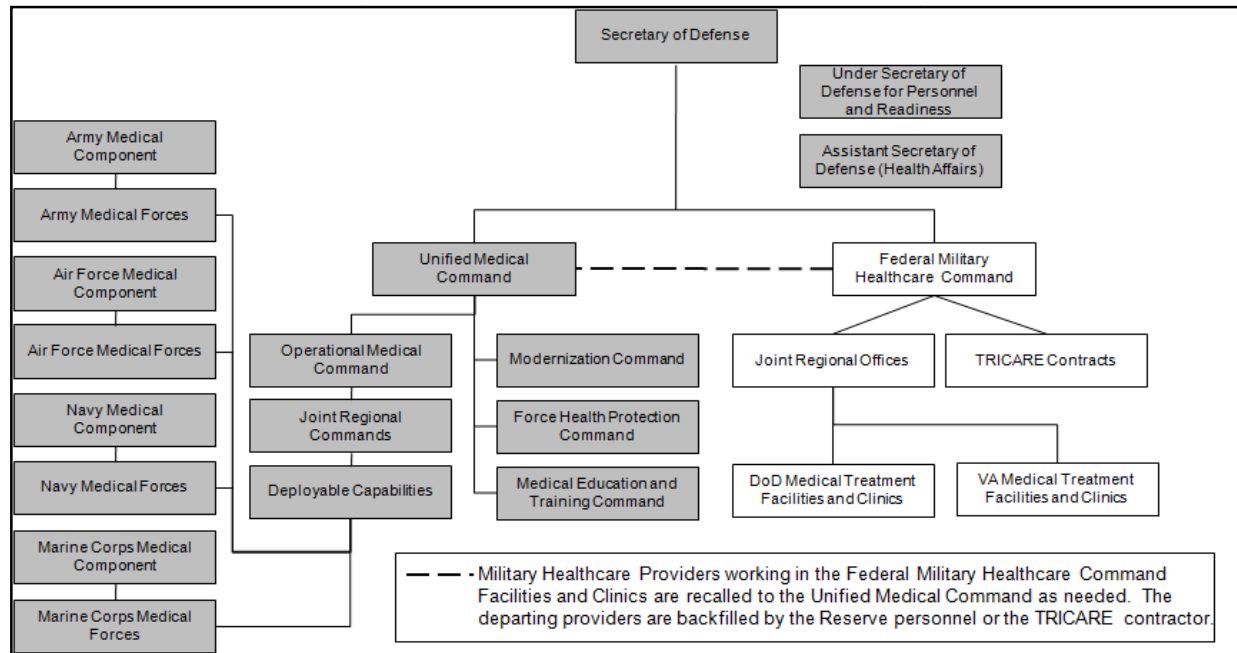


Figure 4. Department of Defense Option

Concept description: The Assistant Secretary of Defense (Health Affairs) provides operational oversight for the newly created “Federal Military Healthcare Command” consisting of all VA and DoD medical treatment facilities and clinics under DoD’s single line of authority. The Federal Military Health Command would combine the current functions of TMA and the VHA headquarters and manage the consolidated system using the existing TRICARE Management Activity (TMA) system of TRICARE Regional Offices (TROs). Additional TROs could be established if the total number of DoD and VA facilities proves to be too large a span/scope of control. The Unified Medical Command would retain control of the operational medical command, modernization command, force health protection command and medical education and training command.

Discussion: This option provides unity of command as one Department would be responsible for both the Unified Medical Command and the Federal Military Healthcare Command. The TRICARE Management Activity (TMA), now proposed to be part of the

Federal Military Healthcare Command, has extensive experience maintaining a health care plan and already has a well developed geographic network of civilian healthcare providers. This option also enhances military medical readiness by maintaining a direct line of authority over a large pool of medical personnel who work in DoD/VA facilities on a daily basis and are available to serve as a rotational base for the tactical medical commands.

The risks associated are that this option requires significant DoD medical system reorganization. The DoD healthcare system would need to absorb the VA's unique services such as long term rehabilitation, domiciliary care, nursing homes, etc. A healthcare system this robust and diverse may prove too much of a distraction from DoD's core mission. It is not advisable for the Secretary of Defense to be responsible for running one of the largest, most comprehensive government healthcare systems in the nation. Removing the responsibility for the provision of health care to veterans from the VA may subject it to loss of cabinet level status. Additionally, it is anticipated that this opposition will meet significant resistance from the VSOs as they may perceive this option to be a risk to their priority for access to healthcare.

Veterans Affairs Option

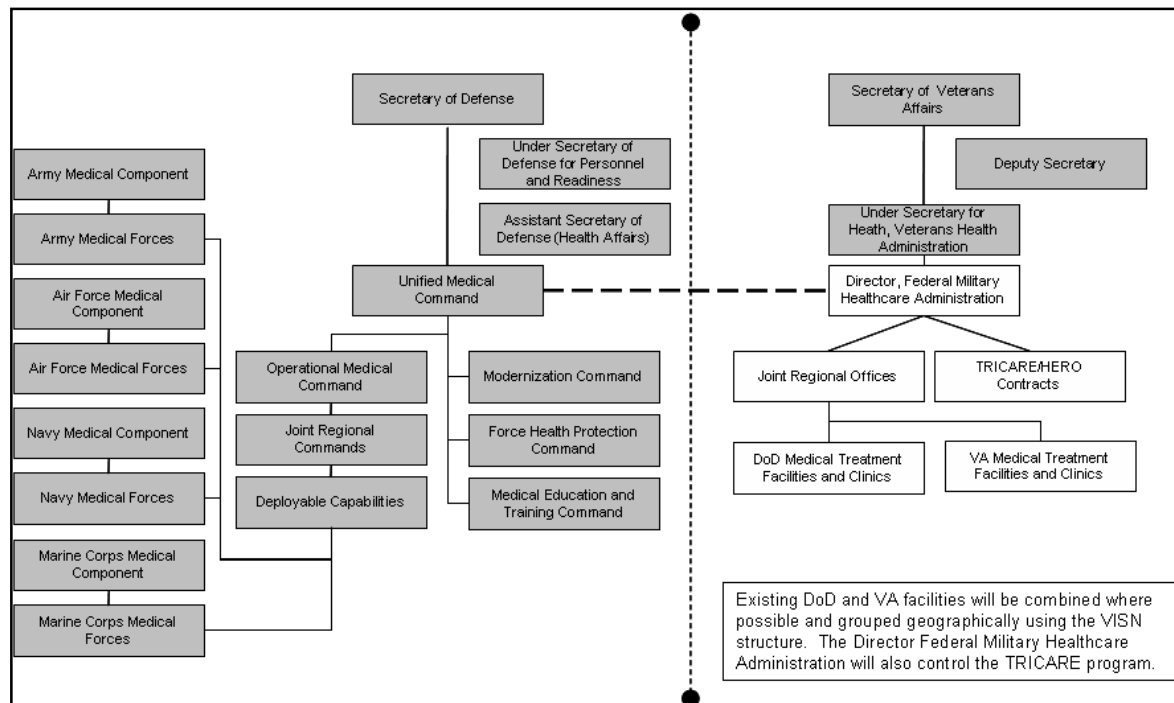


Figure 5. Veterans Affairs Option

Concept description: The Under Secretary for Health, VHA would be the executive agent of the proposed “Federal Military Healthcare Administration” where all existing DoD and VA healthcare facilities and clinics would be geographically grouped using the current VISN structure consisting of 21 regions. Legislative guidance will clearly define the DoD’s Unified Medical Command’s ability to request medical personnel augmentation to maintain readiness using a personnel recall system similar to the U.S. Army’s Professional Officer Filler Information System (PROFIS) system. Active duty healthcare providers and enlisted support personnel would work in the Federal Military Healthcare Administration on a daily basis and be recalled as needed. As these providers are recalled for deployments, training and other military requirements TMA, proposed to be under the command and control of the VA, would backfill the deployed providers or release beneficiaries into its extensive network of civilian healthcare providers. DoD’s Unified Medical Command would retain control of the operational medical command, modernization command, force health protection command and medical education and training command. Additionally, DoD could temporarily assign personnel to senior leadership positions at the various VA healthcare facilities to monitor compliance with the readiness mission. This is very similar to the current organizational leadership structure at North Chicago VAMC- Naval Clinic Great Lakes where the deputy commander position of the healthcare facility remains a DoD billet. Large medical facilities at strategic geographic locations would be run by the VHA but maintain a heavy military medical presence. These facilities would serve as military causality reception Centers of Excellence.

Discussion: This concept allows DoD leadership at all levels to focus on their core mission and not the requirements of running a comprehensive healthcare system. Detailed legislative guidance will clearly define the VA’s responsibility to make medical personnel available to augment the Unified Medical Command as needed in order to maintain DoD’s medical readiness. This option provides consistent leadership as VHA leaders typically are not subject to as many permanent changes of station (PCS) as DoD personnel. Absorbing the responsibility for “brick and mortar” military healthcare can be accomplished by the VHA with the relatively little system adaptation. The VHA currently operates a comprehensive healthcare system and would require the least “re-tooling” of its healthcare system in order to provide the robust pediatrics and obstetrics and gynecology services needed by DoD’s female and children beneficiaries. This option also best addresses the current problems of

seamless transition and changing demographics as OEF/OIF women veterans move into the existing VA system.

This option does have the potential to negatively affect military medical readiness as it will require interdepartmental coordination between the proposed DoD Unified Medical Command and the VA Federal Military Healthcare Administration to request personnel for military training exercises, deployments, and other national emergencies. It also subjects the office of the ASD (HA) to potential downsizing and restructuring.

Health and Human Services Option

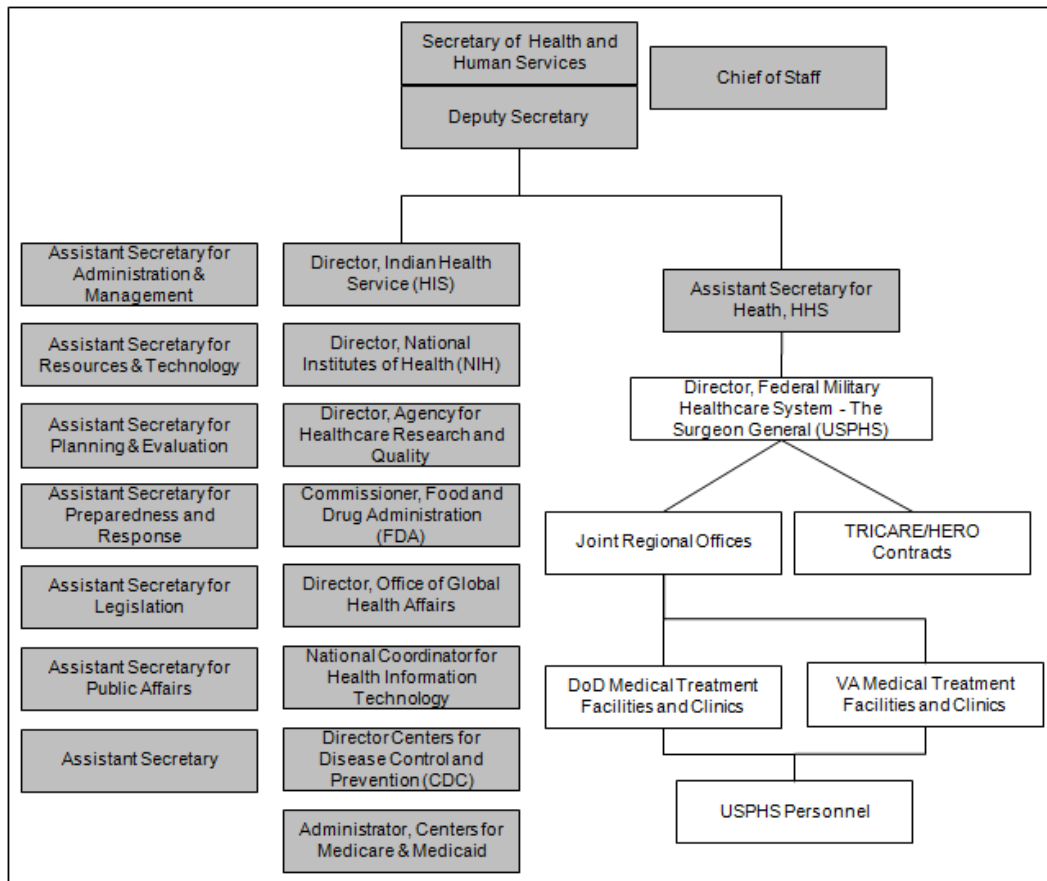


Figure 6. Health and Human Services Option

Concept description: All existing DoD, VA, and HHS healthcare facilities and clinics would be geographically grouped using the existing HHS system of ten regional offices, and operate under the strategic guidance of the Assistant Secretary for Health (ASH) who currently oversees the U.S. Public Health Service (USPHS) Commissioned Corps. The ASH

will work in close coordination with organizational peers in the VA and DoD. Under the supervision of the ASH, the Surgeon General of the USPHS will provide operational command of the new Federal Military Healthcare System. Final authority for management of the combined healthcare system would reside with the Secretary of HHS. Through specific legislative guidance, DoD's readiness mission will be maintained by recalling identified medical personnel using a personnel recall system, similar to the U.S. Army's Professional Officer Filler Information System (PROFIS) system. Active duty healthcare providers and support personnel work in various locations throughout the HHS system of healthcare facilities and would be recalled for deployments, training and other military requirements as needed. DoD's Unified Medical Command (not pictured above) would retain control of the operational medical command, modernization command, force health protection command and medical education and training command.

Discussion: This option would create synergy with other Federal healthcare programs (i.e. Medicare, Medicaid, Federal Occupational Health, Commissioned Corps of the U.S. Public Health Service, and Indian Health Service). Healthcare professionals would be able to work in multiple different environments which may enhance retention. There is also precedent for inter-departmental agreements with HHS as defined by the Economy Act, 31 U.S.C. Section 1535 which encourages interagency agreements that are in the best interest of the Government. In February 2003, the Department of Health and Human Services and Veterans Affairs signed a Memorandum of Understanding (MOU) to promote cooperation and sharing between the VHA and the Indian Health Service (IHS) to further each Department's respective mission.⁷⁸ Placing the new organization under the HHS has the strong potential to eliminate multiple healthcare plan options for eligible beneficiaries. Currently, military retirees can pick and choose between three and four healthcare programs. While the virtues are noted, this option is easily the most complex and difficult to immediately implement because it requires extensive coordination among three Cabinet-level Departments.

RECOMMENDATION AND IMPLEMENTATION

Recommend the single governance structure option with the Under Secretary for Health, Veterans Health Administration as the executive agent of the Federal Military Healthcare Administration (see Figure 5). This option allows military commanders at all levels to focus

on execution of their core mission and not the requirements of running a comprehensive healthcare system. Again, detailed legislative guidance will need to clearly define the VA's responsibility to release military medical personnel in order to augment the Unified Medical Command as needed in order to maintain DoD's medical readiness. This option also provides a more stable leadership base as VHA leaders typically are not subject to as many permanent changes of station (PCS) as DoD personnel. With its extensive system of primary care, surgical, specialty services, rehabilitation, long term mental health facilities, and nursing homes the VHA already operates a robust healthcare system and it would also be easier for the VHA to assume responsibility for "brick and mortar" military healthcare with relatively little system adaptation. The VHA would require the least "re-tooling" in order to provide pediatrics and obstetrics services needed by the DoD women and children beneficiaries. This option also best addresses current problems of seamless transition and changing demographics as OEF/OIF women veterans move into the existing VA system.

Although there is significant merit in aligning all Federal medical programs under the HHS, this option is not recommended because of the complexity of the effort. Although the HHS did provide oversight of a small number of Uniformed Services Treatment Facilities (USTF) until 1982, the Department is not currently structured to provide the required administrative and clinical oversight of such a large healthcare system. While merging the VA and DoD Healthcare systems with the HHS may be the most innovative single governance structure, is simply too difficult to implement. Additionally, DoD should not assume responsibility for the proposed single governance structure because the requirements of operating such an extensive healthcare system will create too significant a distraction from its core mission.

Recommended Implementation Plan

Recommend proceeding with the DoD/VA healthcare system merger using the key practices and implementation steps for mergers and organizational transformations found in GAO Congressional Report 03-669 and listed in Table 1 as a guide.⁷⁹

Table 1: Key Internal Practices and Implementation Steps for Mergers and Organizational Transformations

Practice	Implementation Step
1. Ensure top leadership drives the transformation. Leadership must set the direction, pace, and tone and provide a clear, consistent rationale that brings everyone together behind a single mission.	<ul style="list-style-type: none"> • Define and articulate a succinct and compelling reason for change. • Balance continued delivery of services with merger and transformation activities.
2. Establish a coherent mission and integrated strategic goals to guide the transformation.	<ul style="list-style-type: none"> • Adopt leading practices for results oriented strategic planning and reporting.
3. Focus on a key set of principles and priorities at the outset of the transformation	<ul style="list-style-type: none"> • Embed core values in every aspect of the organization to reinforce the new culture.
4. Set implementation goals and a timeline to build momentum and show progress from day one	<ul style="list-style-type: none"> • Make public implementation goals and timeline. • Seek and monitor employee attitudes and take appropriate follow-up actions. • Identify cultural features of merging organizations to increase understanding of former work environments. • Attract and retain key talent. • Establish an organization wide knowledge and skills inventory to exchange
5. Dedicate an implementation team to manage the transformation process	<ul style="list-style-type: none"> • Establish networks to support implementation team. • Select high-performing team members.
6. Use the performance management system to define responsibility and assure accountability for change	<ul style="list-style-type: none"> • Adopt leading practices to implement effective performance management systems with adequate safeguards.
7. Establish a communication strategy to create shared expectations and report related progress	<ul style="list-style-type: none"> • Communicate early and often to build trust. • Ensure consistency of message. • Encourage two-way communication. • Provide information to meet specific needs of employees.
8. Involve employees to obtain their ideas and gain their ownership for the transformation	<ul style="list-style-type: none"> • Use employee teams. • Involve employees in planning and sharing performance information. • Incorporate employee feedback into new policies and procedures. • Delegate authority to appropriate organizational levels.
9. Build a world class organization	<ul style="list-style-type: none"> • Adopt leading practices to build a world class organization.

Source: GAO-03-669 Merger and Transformation Steps

Incremental Approach - Single Governance Phase 0

Form an interdepartmental transition team under the supervision of the JEC. The team develops a detailed business plan outlining the cost benefits of the merger, conducts information briefings, and other studies as required in order to gain concurrence from DoD, VA, and legislative leadership that the proposed governance will not negatively affect military readiness or disenfranchise VA beneficiaries. Find several champions. Gain senior political support within the VA, the House Armed Services Committee, the Senate Armed Services Committee, the House Appropriation Committee, the Senate Appropriation Committee, and DoD - specifically at the Joint Staff and Service Chief level. Sell the concept to the VSOs and other political organizations. Include comprehensive instructions in a future NDAA that codifies the merger with both short and long term phasing. (See Annex E).

Incremental Approach - Single Governance Phase I

In Phase I of the recommend option, the existing DoD and VA command structures remain in place. The DoD and VA agree to create Federal Military Healthcare Administration programs where one Department has a single line of authority over a specific program or service. These will not be joint or shared services/programs but one Department will be responsible for providing the service to both DoD and VA beneficiaries. This is very similar to the “purple suit” concept except in this case it would be a “Federal suit.” Healthcare providers and support staff working in the Federal Military Healthcare Administration programs would be temporarily detailed to the other Department. The Federal Military Healthcare Administration medical programs would function very similarly to the current Defense and Veterans Brain Injury Center (DVBIC), where a group of seven traumatic brain injury (TBI) programs in Department of Defense (DoD) and Department of Veterans Affairs (VA) hospitals and two civilian TBI rehabilitation programs are combined into one, centrally managed program. The DVBIC sites work collaboratively to provide and improve TBI care for active duty military and reserve component military personnel, veterans, and their eligible beneficiaries.⁸⁰

Determining which Department has responsibility for the service or program should be based on existing capabilities and historical strengths. For example, the VHA operates a domiciliary service, has long been a leader in Physical Medicine and Rehabilitation and Behavioral Health programs so they have single line of authority for the Federal Military Healthcare Administration programs in these fields.

Phase I Short Term Objectives:

- Gradually eliminate the DoD's Graduate Medical Education system and augment/adopt the VA's method of partnering with medical schools and universities. The VHA is the nation's largest provider of graduate medical education and a major contributor to medical and scientific research. VA partners with 107 medical schools and 2,000 colleges or universities. DoD would maintain its system of medical education (i.e. Uniformed Services University of the Health Sciences and the Health Professions Scholarship Program) as a source for dedicated military physicians.
- At risk of disenfranchising the wounded warriors, recommend placing them in a Temporary Disability Retirement List (TDRL) status and have the VA assume responsibility for the Army's Wounded Warrior Program, to include the Warrior Transition Units (WTUs). The primary mission of service members in the WTUs is to heal and this fits perfectly with the VHA's ethos. The Wounded Warrior program is very similar to the current VHA domiciliary program where veterans are case managed and closely monitored. Active duty cadre can be detailed to the VHA to provide command and control and assist in the management of the wounded warriors. When a wounded warrior enters the program they are detailed to the VA pending a medical decision. Once a wounded warrior has healed he/she can apply to return to the active duty ranks. Again, this approach requires education, training, and care, as wounded warriors may feel abandoned by the DoD after making significant personal sacrifice.
- Replace redundant administrative systems - Eliminate the Project HERO program after merging it with TRICARE's existing managed care network. Eliminate one Department's electronic health record, logistics supply systems, financial system after conducting "best of breed" competitions. Convert all successful national sharing initiatives (i.e. pharmacy management) into Federal Military Healthcare Administration Ancillary Service Programs.
- Physical Medicine and Rehabilitation (PM&R) Service - Create a combined Federal Military Healthcare Administration Physical Medicine and Rehabilitation Service. The VHA would be the executive agent for the consolidated service. Physical medicine and rehabilitation is a core competency of the VHA system and the VHA is better positioned to assume responsibility for providing rehabilitation care for both DoD and VA beneficiaries. The VA would assume responsibility for the Center for the Intrepid in San Antonio, Texas.

- Behavioral Health Programs - Combine DoD/VA behavioral health assets and create a Federal Military Healthcare Administration Behavioral Health Service run by the VHA. Combine Rehabilitation Psychology, Traumatic Brain Injury (TBI); Post Traumatic Stress Disorder (PTSD) in a manner similar to the DVBIC.
- Obstetrics Service - The VA has a new demand for Obstetric services created by the OEF/OIF veteran. Recommend creating a Federal Military Healthcare Administration Obstetrics Service with the DoD as the executive agent for the consolidated service which will be provided at DoD medical facilities. The potential difficulty granting non-DoD personnel access to military installations has been resolved at multiple installations.
- Dental Service - Create a Federal Military Healthcare Administration Dental Service for both DoD and VA beneficiaries with DoD as the executive agent for the consolidated program. DoD provides a significant portion of the current resource sharing programs.
- Ancillary Services - The large number of current DoD/VA resource sharing agreements for ancillary services demonstrates a natural recommendation for creating a Federal ancillary service program where DoD/VA Radiology, Pathology, Diagnostic Radiology, and pharmacy assets are combined.

Incremental Approach - Single Governance Phase II

After the Federal Military Healthcare Administration medical programs are established and the inevitable administrative and clinical issues are resolved, begin to merge the current command structures at the below Joint Venture locations into a single governance structures. These locations should be the earliest to merge based on their current level of DoD/VA integration. All the lessons learned from the matured efforts to create a single governance model in North Chicago VAMC – Naval Clinic Great Lakes would be applied. As the military commander of the joint venture locations departs, replace with a VA Director. Initially retain one or multiple deputy commanders from DoD.

- **Anchorage, Alaska**

3rd Medical Group, Elmendorf AFB/Alaska VA Health Care System

- **North Chicago, Illinois**

Naval Health Clinic-Great Lakes/North Chicago VA Medical Center

- **Honolulu, Hawaii**

Tripler Army Medical Center/VA Pacific Islands Health Care System (Spark M. Matsunaga Medical Center)

- **Key West, Florida**

Naval Branch Health Clinic Key West/Miami VA Health Care System (Community Based Outpatient Clinic)

- **El Paso, Texas**

William Beaumont Army Medical Center/El Paso VA Health Care System

- **Fairfield, California**

David Grant Medical Center, 60th Medical Group, Travis AFB/Northern California VA Health Care System

- **Las Vegas, Nevada**

99th Medical Group, Nellis AFB/VA Southern Nevada Health Care System (Michael O'Callaghan Federal Hospital)

- **Albuquerque, New Mexico**

377th Medical Group, Kirtland AFB/New Mexico VA Health Care System

Incremental Approach - Single Governance Phase III

As the single governance structure at the joint venture locations mature, consolidate the regional level commands into one structure. Once the regional mergers are complete, consolidate the MHS and VHA into a single Federal Military Healthcare Administration governance structure at the national level.

CONCLUSION

Current efforts to improve DoD/VA collaboration and implement over 400 recommendations from five major studies are to be commended. Many dedicated and talented individuals from both Departments have worked hard to meet the intent of senior DoD, VA and Legislative leadership. In efforts to quickly improve collaboration, the pattern has been that each Department stands-up similar functional offices or places liaisons in each others' organization. This has resulted in the creation of multiple full time equivalents positions and redundant functions which may have not been necessary if a single governance structure had been in place. The history of DoD/VA sharing is replete with examples of failed attempts and difficulties getting the two large organizations to effectively

cooperate. Until a national authority establishes a single management or governance structure, public laws, bureaucracy, and organizational culture will limit the extent and success of collaboration efforts between DoD and VA healthcare systems. While this may seem too simplistic an approach, the end result will be a more efficient healthcare system better prepared to respond to national contingencies.

If left alone, large scale change is not going to happen by itself. We can continue down the road of increasing resource sharing, joint ventures, and sharing when it makes sense and is mutually beneficial, or we can make the quantum leap, change public law, and create a new Federal entity that reduces bureaucracy, maximizes synergy, and enhances the quality of care for all beneficiaries and at a reduced cost to the taxpayer. The latter meets both the sense of Congress and the needs of our service members and veterans.

ANNEX A

***Departments of Defense (DoD) – Veterans Affairs (VA)
Sharing Opportunities in Central Texas***



WHITE PAPER

16 January 2008

Department of Defense (DoD) – Veterans Affairs (VA) Sharing Opportunities in Central Texas

Introduction

As Commander III Corps and Fort Hood, Lieutenant General Ray Odierno prioritizes replacing the existing Carl R. Darnall Army Medical Center (CRDAMC), opened in 1964 at Fort Hood, Texas, with a robust, state of the art medical campus. His primary objective is to ensure that the new facility, currently in design, will provide exceptional care for wounded warriors and reduce the cost and stress placed on Soldiers and their families traveling outside of the local area for care. He intends to leverage the combined assets of the Military Health System (MHS), Veterans Health Administration (VHA), state medical academia, and local civilian healthcare systems in a revolutionary approach to health care for the 150,000 Department of Defense (DoD) beneficiaries and the 77,000 veterans in the Fort Hood area (see Annex A).

Despite expressed interest from local civilian healthcare systems, a study completed by the Noblis Group found no ability or commitment from these organizations to provide capital investment in the new CRDAMC. This necessitates a Departments of Defense and Veterans Affairs funding solution.

A unique opportunity exists for Fort Hood to forge unprecedented partnerships with the Central Texas Veterans Healthcare System (CTVHCS) and the Texas A&M School of Medicine to increase the number of Graduate Medical Education (GME) programs, create a Behavioral Health Center for Excellence, a state of the art Rehabilitation Center, a VA Community Based Outpatient Clinic, a robust VA Compensation and Pension Clinic, and a Transition Assistance Program office all located on the new medical campus at Fort Hood.

By leveraging the power, prestige, and medical expertise of Army medicine, Army Medical Command (MEDCOM) can advance the VA and Texas A&M's interest in this project from the conceptual to the actual. By working with the VA at levels that Fort Hood cannot reach, MEDCOM can provide the key push that will lead to concrete coordination with the VA in accordance with the needs of Fort Hood Soldiers and population, as well as satisfying Congressional mandates.

This effort is of great interest to U.S. Senator Kay Bailey Hutchinson, Texas; U.S. Senator John Cornyn, Texas; Congressman John Carter, 31st District of Texas; Congressman Chet Edwards, 10th District of Texas; Mr. Bruce Gordon, Director Central Texas Veteran's Health Care System; Mr. William Thresher, MEDCOM Chief of Staff; Dr. Michael D. McKinney, MD., Chancellor of the Texas A&M University System; Dr. Nancy W. Dickey, MD., President, Texas A&M Health Science Center and Vice Chancellor for Health Affairs; along with local leaders and influential citizens in Central Texas.

Purpose

To provide the MEDCOM Chief of Staff and other interested parties information regarding the potential to increase collaboration between the existing and future Carl R. Darnall Army Medical Center (CRDAMC) at Fort Hood, the Central Texas Veterans Health Care System (CTVHCS) at Temple/Waco, and the Texas A&M University School of Medicine.

Problem Statement

While III Corps, CTVHCS, CRDAMC, and Texas A&M University have expressed interest in developing an innovative approach to Graduate Medical Education (GME) and Federal Healthcare in Central Texas, there has been no formal engagement among all senior leaders to frame and discuss the issue, determine the necessary level of commitment to the effort, and take action together.

The current design for the future CRDAMC medical campus does not demonstrate a shared vision among CTVHCS, CRDAMC and III Corps leadership for major initiatives such as a joint Rehabilitation Center of Excellence, PTSD/TBI Center of Excellence, and other shared programs.

Recommendation

A Federal Healthcare Summit, with representation from the Office of The Surgeon General, VHA, Veterans Integrated Services Network (VISN) 17, III Corps, Great Plains Regional Medical Command (GPRMC), CRDAMC, CTHVCS, and Texas A&M, is needed to develop a shared vision and charter a joint task force responsible to develop creative methods to increase the amount of collaboration between CRDAMC, CTVHCS and Texas A&M. The task force would also be responsible for developing an innovative approach to the delivery of Federal Healthcare in Central Texas. Request MEDCOM engage senior VA leadership,

Texas A&M officials, and other key leaders to determine willingness to participate in the summit recommended to be held at Fort Hood/Killeen in the April/May 2008 time frame.

The objectives of the summit are as follows: bring national attention to DoD/VA sharing in Central Texas, increase communication between CRDAMC, CTVHCS and Texas A&M, immediately improve access to care for all beneficiaries through increased sharing, identify joint venture/sharing projects that may influence the campus design of the new CRDAMC, identify and resolve potential barriers to sharing, consolidate all current resource sharing agreements into one master agreement (with distinct annexes), and charter a joint integration task force and strategic planning committee.

Background

It is important to note that this is an unusual scenario due to significant legislative interest in DoD/VA partnerships and Federal Healthcare in general. Recent language in the pending National Defense Authorization Act (NDAA) requires a comprehensive policy to address traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), other mental health conditions and military eye injuries, as well as the creation of centers of excellence focused on these conditions.

Adding to the urgency is the level of engagement of the senior Fort Hood leadership and their desire to provide an unprecedented but critically needed level of local medical support to Soldiers and their family members returning from and deploying to OEF/OIF. For multiple reasons, CRDAMC inconsistently meets access standards in primary and specialty care resulting in the network referral of approximately 3,500 beneficiaries each month. Limited access to behavioral health professionals remains a significant concern.

MEDCOM and GPRMC have increased CRDAMC's staff to meet the additional demand. Both have also supported the development of the III Corps vision for the future CRDAMC by initially contracting Wingler & Sharp Architects in October 2006 and then The Noblis Group in April 2007 for market analysis and facility design. Each group completed multiple visits to the central Texas area and conducted meetings with key Federal and civilian stakeholders such as Scott & White in Temple, Metroplex Health System in Killeen, Kings Daughters Hospital in Temple, III Corps, Great Plains Regional Medical Command (GPRMC) in San Antonio, CRDAMC, and the CTVHCS in Temple.

Initial discussion with CTVHCS revealed unified support for a joint venture Community Based Outpatient Clinic (CBOC) in the campus design of the replacement medical facility at Fort Hood. Research of both facilities' referral patterns supports additional sharing opportunities - with these services provided at either CRDAMC or the existing CTVHCS facilities in Temple and Waco - in Medical/Surgical product lines, Women's Health, Behavioral Health, Rehabilitation Services, and DoD/VA joint GME programs (see Annex B). Texas A&M has also expressed interest in conducting multidisciplinary Graduate Medical Education (GME) at CRDAMC.

While all have expressed interest, there has been limited communication between the senior leadership of III Corps, VISN 17, GPRMC, CTVHCS, CRDAMC, and Texas A&M. A common vision does not exist for shared GME and the types of joint DoD/VA medical services available for beneficiaries at CTVHCS (Temple/Waco) and the existing and future CRDAMC.

Current DoD/VA Level of Effort (LOE) between CRDAMC - CTVHCS

Applying a continuum relationship grid to determine level of sharing between DoD and VA assets shows CTVHCS and CRDAMC to be distinctly separate facilities (see Annex C). According to the FY 07 DoD/VA Sharing Agreement Database, there were no joint venture agreements and nine sharing program agreements between CRDAMC and CTVHCS (Temple/Waco). Further discussion with GPRMC, CTVHCS and CRDAMC staffs revealed there were five active sharing agreements with a total monetary transaction amount of \$715,248 dollars in FY07. The Separation Physical (2001-FRS-0091A) and Sleep Studies (2003-FRS-004) sharing agreements exchanged services but not money. The Red Blood Cells (2001-FRS-073A) sharing agreement is an active contingency support agreement. The sharing program agreement for Mental Health Services (2005-FRS-0088) is one of the more innovative sharing agreements and demonstrates potential for future initiatives. This agreement allowed CRDAMC's Behavioral Health Service to hire additional mental health professional using the VA's more flexible and responsive hiring procedures. While this success is noteworthy, the overall limited amount of sharing agreements highlights the lack of communication between the two Federal organizations and demonstrates this is a difficult problem requiring senior leadership's involvement.

Agreement	Type of Service Provided	DoD Paid to VA	VA Paid to DoD
2001-FRS-0091A	Separation Physicals	0	0
2005-FRS-0070	Laundry Services	\$439,800	0
2001-FRS-073A	Red Blood Cells	0	0
2003-FRS-004	Sleep Studies	0	0
2005-FRS-0088	Mental Health Services	\$275,448	
Total		\$715,248	

Table 1. FY07 Sharing Agreements

Current DoD/VA Level of Effort (LOE) between CRDAMC - CTVHCS not in a sharing agreement

Currently there is one OEF/OIF Transition Liaison Full Time Equivalent (FTE) and one Transition Assistance Patient Advocate FTE at CRDAMC. Current plans are to hire two additional FTEs and create a transition office in CRDAMC. The OEF/OIF transition program administered by the CTVHCS has a total of 16 FTEs.

Potential DoD/VA sharing opportunities at the existing facilities

Table 2. below, identifies product lines where sharing opportunities should be explored in detail prior to the Federal Healthcare Summit in April/May 2008. This table was created following a meeting with CRDAMC's Deputy Commander for Clinical Services (DCCS) and CTVHCS' Deputy Chief of Staff. The next step is to evaluate the feasibility of the sharing initiative, determine the type of agreement (i.e. resource sharing agreement or joint venture), and if the initiative is eligible for the Joint Incentive Fund (JIF) program. These discussions may yield areas of focus for the proposed Federal Healthcare Summit in April/May 2008.

Product Line	Potential Sharing Actions	Comments
Behavioral Health	Refer all PTSD (inpatient) to the VA center of excellence in Waco. Review all current programs to determine where additional sharing opportunities exist.	Increased sharing initiatives in the behavioral health product line have the most promise for quick success.

Physical Medicine and Rehabilitation	Explore referring all CRDAMC to exiting facility in Temple. CTVHCS is exploring adding fifteen rehabilitation beds to its inpatient rehab service.	This includes TBI.
OB/GYN	Refer all VA OB patients to CRDAMC.	Increasing number of child bearing age women entering the VA system. Population expected to grow from 1,000 to 8,000 by FY2010.
Cardiology	Shared cardiologist at either CTVHCS (S&W) or CRDAMC.	Both facilities demonstrated a need for increased cardiology services.
Graduate Medical Education (GME)	Explore if it is feasible to establish joint DoD/VA GME programs.	Currently being reviewed by MEDCOM
Warrior Transition Unit (WTU) staffing	Staff WTU with VA staff to assist in the transition of the beneficiary to the VA system	Vast majority of the WTU will be transitioning to the VA healthcare system.

Table 2. Potential product lines for DoD/VA sharing

DoD/VA sharing opportunities influencing the design of the new CRDAMC

III Corps' vision for the new CRDAMC includes a proposal for approximately 20,000 Sq Ft of space for a Community Based Outpatient Clinic (CBOC), a Joint Rehabilitation Center, a joint PTSD/TBI center, an expanded Compensation and Pension Clinic, a Transition Assistance Program office, and expanded Social Work Services. The final square footage requirement may be adjusted based on success of new sharing initiatives and highlights the need for the summit as a guide for both DoD and VA future planning.

Graduate Medical Education (GME) Programs

CRDAMC has a long standing and successful history of conducting Graduate Medical Education at Fort Hood. For the past several years, CRDAMC's Emergency Medicine Residency Program has produced residents who have achieved the top score on the annual in-service exam out of the 127 programs across the nation. CRDAMC also maintains a very successful Family Medicine Residency Program and trains residents from Brooke Army Medical Center (BAMC) in Pediatrics, Obstetrics, Orthopedics, General Surgery, and Otolaryngology. All CRDAMC's programs remain fully accredited by the Accreditation Council for Graduate Medical Education (ACGME).

The Army's GME office is conducting an analysis to determine if the beneficiary population and case mix index supports expanding the number of GME programs currently at CRDAMC. At this point, neither the Texas A&M School of Medicine nor the Director of Medical Education at CTVHCS has been officially engaged with detailed proposals.

With Fort Hood's proven success in GME, its growing Active Duty, Active Duty Family Member, and retiree population combined with the potentially available veteran population sets the conditions for a very successful shared DoD/VA GME programs in additional medical and surgical specialties.

Conclusion and Restated Recommendations

The timing is perfect for an innovative approach to the provision of Federal Healthcare in Central Texas. Health care services for both DoD and VA beneficiaries in product lines such as Behavioral Health are expanding at a rapid pace leaving both organizations not fully aware of the efforts of the other. To meet legislative mandates for increased cooperation and to optimize the care we provide, we need a joint summit to discuss and develop a shared vision for the future of Federal Healthcare in Central Texas.

Recommend conducting a Federal Healthcare Summit to develop a shared vision and charter a joint task force responsible to develop creative methods to increase collaboration between CRDAMC, CTVHCS and Texas A&M. The task force would also be responsible for developing an innovative approach to the delivery of Federal Healthcare in Central Texas. Recommend the proposals of the task force be briefed to the III Corps, VISN 17, GPRMC, and Texas A&M leadership in a joint session NLT July 2008.

(WHITE PAPER - ANNEX A)

Beneficiary Demographics

County-Level Veteran Population FY06-FY13 – All Age Groups

County	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
<i>Bell</i>	33,146	32,855	32,448	32,025	31,546	30,422	29,786
<i>Burnet</i>	4,247	4,406	4,625	4,711	4,785	4,841	4,890
<i>Coryell</i>	9,734	9,518	9,320	9,149	8,992	8,862	8,720
<i>Lampasas</i>	2,735	2,728	2,706	2,685	2,640	2,619	2,591
<i>Williamson</i>	27,546	27,771	27,931	28,030	28,208	28,214	29,200
Total	77,408	77,278	77,030	76,600	76,171	74,958	75,187

Note: The data source is ProClarity. Although these projections do not show substantial growth, the VA is studying the impact of easing eligibility restrictions for Priority 8 veterans as defined by the Veterans Benefits Improvement Act of 1994. Additionally, these projections do not take into consideration the increasing number of Priority 1-6 veterans from OEF/OIF. A study conducted by Linda Bilmes, John F. Kennedy School of Government - Harvard University, suggests OEF/OIF veterans will produce an unanticipated growth of between 17% and 24% in the under 65 veteran population.

CRDAMC Population FY06-FY13 – All Patient Categories

Category	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
<i>Active Duty</i>	45,134	47,955	47,469	43,635	40,164	40,363	39,510
<i>Guard</i>	720	722	718	583	449	445	450
<i>ADFM</i>	57,696	58,338	58,325	53,247	49,807	49,746	48,624
<i>Guard FM</i>	2,192	2,111	2,113	1,694	1,258	1,249	1,264
<i>Retired / RFM</i>	40,949	40,895	40,553	40,429	39,799	39,001	38,579
<i>65+</i>	10,839	11,357	11,851	12,265	12,595	12,982	13,529
Total	157,530	161,378	161,029	151,853	144,072	143,786	141,956

Note: The Managed Care Forecasting and Analysis System (MCFAS) used by MEDCOM shows a decline in Active Duty population which drives the rest of the population data. This is significantly different than the population data contained in the Army Stationing and Installation Plan (ASIP) and the "Grow The Army" (GTA) initiative. According to the GTA, Fort Hood will receive one Air Defense Brigade Headquarters, one Air Defense Patriot Battalion in 2008 and one Sustainment Brigade in 2011 and is expected to grow by 3,273 Soldiers. Additionally, a 19 December 2007 GTA information brief projects Ft. Hood's Active Duty and civilian population to be **49,632** by FY13.

(WHITE PAPER - ANNEX B)

What CTVHCS needs to recapture/expand: (Top Referrals-Potential sharing areas)

<i>All Primary ICD9</i>	<i>Disbursed Amt</i>	<i>Unique Patients</i>
Diseases of the Circulatory System	\$ 6,166,695	843
Neoplasms	\$ 6,034,800	652
Diseases of the Respiratory System	\$ 2,406,984	480
Diseases of the Genitourinary System	\$ 3,210,935	355
Symptoms, Signs, and Ill-Defined Conditions	\$ 3,107,769	1,233
Diseases of the Digestive System	\$ 1,557,762	444
Injury and Poisoning	\$ 1,910,641	304
Complications of the Pregnancy, Childbirth, and the Puerperium	\$ 319,137	111
Total	\$ 24,714,725	4,422

Note: The data source is non-VA cube in ProClarity and includes the FY07 disbursed amount for purchased care generated by the healthcare needs of veterans living in the 39 counties served by CTVHCS. Women's health/OB is an increasing requirement due to the projected increased in Obstetrics due to the younger age of the female OEF/OIF veteran now eligible for care in the VA system. Not listed is the need for **additional Primary Care** at CTVHCS in Temple which is a facility space concern. A Community Based Outpatient Clinic (CBOC) in the Fort Hood area would alleviate congestion and improve access to primary care at CTVHCS in Temple.

What CRDAMC needs to recapture/expand: (Top Referrals - Potential sharing areas)

<i>Service</i>	<i>Relevant Value Units</i>	<i>Full Time Equivalents</i>
Social Work Services	17,042	7.1
Psychology	12,042	5.4
Optometry	7,107	1.7
Psychiatry	6,242	2.2
Orthopedics	4,715	.7
Internal Medicine	2,648	.8
Cardiology	2,654	.6

Note: The Relevant Value Unit is based on The Innova Group's analysis of FY 2013 projected workload and a 50% recapture rate which would keep the majority of care local. The projected Full Time Equivalent data is also based on The Innova Group's analysis and defines the additional staff required at CRDAMC to meet the 50% recapture rate.

(WHITE PAPER - ANNEX C)

Continuum Relationship Grid between CRDAMC and CTVHCS

In a December 2003, Mitretek Systems conducted a study of DoD/VA sharing in selected markets and identified nine domains to categorize or group DoD/VA collaboration efforts: Patient Care, Facilities, Staffing, Clinical and Business Processes, Governance and Management, IM/IT, Logistics, Education, and Research. Mitretek's methodology also included a continuum of relationships ranging from the least coordinated (Separate) to the most integrated (Consolidated). Applying Mitretek's relationship grid to CRDAMC and CTVHCS current level of partnership produces the below results highlighted in bold print.

Review of existing CRDAMC - CTVHCS relationship using the Mitretek domains of collaboration.

Domain	Separate	Coordinated	Connected	Integrated	Consolidated
Clinical workload	Insignificant referrals	Regular communication	High number of referrals	Significant number of referrals	Protocol driven placement of all patients
Facilities	Distant	Some sharing were duplication exists	Projects & facilities come from master planning	Many Departments share space	One facility or medical campus
Staffing	Distinct	Support in peaks and valleys	Joint staff planning	Multiple example of joint staffing	Single staffing
Business Practices	Distinct	Reduce barriers	Work flows – understood and acted on	Transparent	Single system
Management & Governance	No relation	Joint planning sessions	Overlap of key functions	Overlap of many key functions	One governance structure
IM/IT	Separate Systems	Evidence of information exchange	Moving towards system interface	Complete interoperability	Unified program
Logistics	Little if any exchange	Borrowing, bartering and contractual exchange	Mutual examination of best practice pricing and service	Selective joint contracting in major procurements	Unified program
Education & Training	Distinct	Selective exchange of methods	Frequent use of joint programs and curriculum	Most programs are same or similar	Unified program
Research	Distinct	Selective exchange of methods	Joint planning and review	Significant overlap of protocol	Unified program

Table 1. Relationship Grid between CRDAMC and CTVHCS

ANNEX B

Veterans Affairs Eligibility Requirements

Priority Group	Definition
Priority 1:	-Veterans determined by VA to be unemployable due to service-connected conditions -Veterans with VA-rated service-connected disabilities 50% or more disabling
Priority 2:	-Veterans with VA-rated service-connected disabilities 30% or 40% disabling
Priority 3:	-Veterans who are Former Prisoners of War (POWs) -Veterans awarded a Purple Heart medal -Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty -Veterans with VA-rated service-connected disabilities 10% or 20% disabling -Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
Priority 4:	-Veterans who are receiving Veterans who are receiving aid and attendance or housebound benefits from VA
	-Veterans who have been determined by VA to be catastrophically disabled
Priority 5:	-Veterans receiving VA pension benefits -Nonservice-connected veterans and noncompensable service-connected veterans rated as 0% disabled by VA and whose annual income and net worth are below the VA pension benefitsVA national income threshold -Veterans eligible for Medicaid programs
Priority 6:	-World War I veterans -Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki -Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge -Compensable 0% service-connected veterans -Project 112/SHAD participants -Veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008, are eligible for the enhanced benefit until January 27, 2011
Priority 7:	-Veterans with income and/or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay copays
Priority 8:	-Veterans with income and/or net worth above the VA national income threshold and the geographic income threshold who agree to pay copays Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date Subpriority e**: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003 Subpriority g**: Nonservice-connected veterans applying for enrollment after January 16, 2003

ANNEX C

DoD/VA Collaboration – Event Timeline

YEAR	ACTION
1982	<ul style="list-style-type: none"> PL 97-174, 38 USC Sec 8111: VA/DoD Health Resources Sharing and Emergency Operations Act
1983	<ul style="list-style-type: none"> DoD/VA MOU signed implementing PL 97-174
1987	<ul style="list-style-type: none"> Inaugural VA-USAF Health Resources Joint Venture, Kirtland AFB, Albuquerque
1992	<ul style="list-style-type: none"> PL 102-585: Veterans Health Care Act
1995	<ul style="list-style-type: none"> DoD/VA MOU outlined VA participation with TRICARE
1996	<ul style="list-style-type: none"> DoD Policy required Lead Agent Offices to review and approve VA TRICARE agreements PL 104-262: Repealed sunset provision under PL 102-585
1997	<ul style="list-style-type: none"> VA/DoD Executive Council established (PL 107-314: established HEC in 2003)
1999	<ul style="list-style-type: none"> DoD legal opinion Congressional Commission on Service Members and Veterans Transition Assistance PL 106-117: Veterans Millennium Health Care and Benefits Act
2000	<ul style="list-style-type: none"> GAO Report: "Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies" (GAO/HEHS-00-52) PL 106-398: FY01 NDAA expands DoD health care benefit for retirees (TRICARE for Life) PL 106-419: Veterans Benefits and Health Care Improvement Act
2001	<ul style="list-style-type: none"> Executive Order 13214: President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (final report delivered in May 2003)
2002	<ul style="list-style-type: none"> VA/DoD Joint Executive Council (JEC) established PL 107-314 (FY03 NDAA): DoD/VA Health Care Sharing Incentive Fund (aka JIF) Health Care Resources Sharing and Coordination Project (aka Demonstration Projects) Health Executive Council (HEC) established
2003	<ul style="list-style-type: none"> PL 108-136: FY04 NDAA codified DoD/VA Joint Executive Council (JEC) DoD/VA Health Executive Council's Reimbursement MOA VA/DoD Benefits Executive Council (BEC) established
2004	<ul style="list-style-type: none"> GAO Report: "VA and DoD Health Care: Resource Sharing at Selected Sites" (GAO-04-792) PL 108-375 (FY05 NDAA): Seamless Transition Consider joint DoD/VA initiatives Army given authority to convey land to VA to build an outpatient clinic

2005	<ul style="list-style-type: none"> • GAO Testimony: "VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited" (GAO-05-1052T) • GAO Testimony: "Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information. (GAO-05-1051T)
2006	<ul style="list-style-type: none"> • GAO Report: "VA and DOD Health Care: Opportunities to Maximize Resource Sharing Remain" (GAO-06-315)
2007	<ul style="list-style-type: none"> • GAO Testimony: "Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Are Far from Comprehensive Electronic Medical Records" (GAO-08-207T) • Presidential Task Force on Care for America's Returning Wounded Warriors (Final report delivered on July 31, 2007)
2008	<ul style="list-style-type: none"> • GAO Report: "VA and DOD Health Care: Administration of DOD's Post-Deployment Health Reassessment to National Guard and Reserve Servicemembers and VA's Interaction with DOD." (GAO-08-181R)

ANNEX D

DoD/VA Collaboration - GAO Reports

GAO Report/Testimony Name	Report Number	Report Date
VA Healthcare: Mild Traumatic Brain Injury Screen and Evaluation Implemented for OEF/OIF Veterans, but Challenges Remain.	GAO-08-276	February 8, 2008
VA and DOD Health Care: Administration of DOD's Post-Deployment Health Reassessment to National Guard and Reserve Servicemembers and VA's Interaction with DOD.	GAO-08-181R	January 25, 2008
VA and DOD Continue to Expand Sharing of Medical Information, but Still Lack Comprehensive Electronic Medical Records.	GAO-08-207T	October 24, 2007
Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers.	GAO-07-1256T	September 26, 2007
Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Are Far from Comprehensive Electronic Medical Records	GAO-07-1108T	July 18, 2007
Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Are Far from Comprehensive Electronic Medical Records	GAO-07-852T	May 8, 2007
Information Technology: VA and DOD Face Challenges in Completing Key Efforts	GAO-07-554R	April 30, 2007
DOD and VA Exchange of Computable Pharmacy Data.	GAO-06-905T	June 22, 2006
VA and DOD Health Care: Opportunities to Maximize Resource Sharing Remain	GAO-06-315	March 20, 2006
Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies	GAO-06-15	October 21, 2005
VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited	GAO-05-1052T	September 28, 2005
Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information.	GAO-05-1051T	September 28, 2005
DOD and VA Health Care: Incentives Program for Sharing Health Resources	GAO-05-310R	February 28, 2005
VA and DOD Health Care: Resource Sharing at Selected Sites	GAO-04-792	July 21, 2004
Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management.	GAO-04-687	June 7, 2004
Computer-Based Patient Records: Improved Planning and Project Management Are Critical	GAO-04-811T	May 19, 2004

to Achieving Two-Way VA-DOD Health Data Exchange.		
Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data.	GAO-04-402T	March 17, 2004
DOD and VA Health Care: Incentives Program for Sharing Resources.	GAO-04-495R	February 27, 2004
Veterans Affairs: Post-hearing Questions Regarding the Departments of Defense and Veterans Affairs Providing Seamless Health Care Coverage to Transitioning Veterans.	GAO-04-294R	November 25, 2003
Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems.	GAO-04-271T	November 19, 2003
DOD and VA Health Care: Access for Dual Eligible Beneficiaries.	GAO-03-904R	June 13, 2003
VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients.	GAO-02-1017	September 27, 2002
VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies.	GAO-02-872T	June 26, 2002
DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs.	GAO-01-588	May 25, 2001
Computer-Based Patient Records: Better Planning and Oversight By VA, DOD, and IHS Would Enhance Health Data Sharing.	GAO-01-459	April 30, 2001
VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies.	GAO/HEHS-00-52	May 17, 2000
VA and Defense Health Care: Rethinking of Resource Sharing Strategies is Needed.	GAO/T-HEHS-00-117	May 17, 2000
VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources.	GAO/HRD-88-51	March 1, 1988
Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles To Interagency Sharing.	HRD-78-54	June 14, 1978

ANNEX E

Proposed Legislation Shell

To amend Titles 10 and 38 to provide for the establishment of a single agency under the authority of the Department of Veterans Affairs, assisted by the Department of Defense, responsible for both military and veteran healthcare, other than that military healthcare directly related to readiness for combat or actual combat operations, to be known as the Military and Veterans Health Services Agency, popularly known as MilVet.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title- This Act may be cited as the 'Military and Veterans' (MilVet) Health Care Transformation Act of 200X'.

(b) Table of Contents- The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Establishment of Funding Authority to allow both current military and veterans health services to provide services to designated beneficiaries under both Titles 10 and 38.

Sec. 3. Establishment of MilVet Health Services under the Undersecretary for Health, Department of Veterans Affairs, with military deputies.

Sec. 4. Consolidation of medical education currently under Department of Defense and Department of Veterans Affairs under the MilVet Health Services.

Sec. 5. Consolidation of Departments of Defense and Veterans Affairs managed care networks, electronic health records, logistic supply, and financial systems under the MilVet Health Services.

Sec. 6. Consolidation of Departments of Defense and Veterans Affairs medical treatment programs, less military medicine necessary to combat readiness, under the MilVet health Service.

Sec. 7. Consolidation of Departments of Defense and Veterans Affairs local, regional, and national health organizations, less military medicine necessary to combat readiness, into the MilVet Health Service.

Sec. 8. Establishment of a schedule for consolidation of military and veterans health programs, and reporting requirement to Congress.

Sec. 9. Technical amendments.

ENDNOTES:

¹ U.S. General Accountability Office, *VA Healthcare: VA and DoD Healthcare: Opportunities to Maximize Resource Sharing* (Washington, D.C.: U.S. General Accountability Office, March 2006).

² U.S. House of Representatives, Committee on Veterans Affairs, Department of Veterans Affairs and Department of Defense Health Resources Sharing Staff Report to the Committee on Veterans Affairs; available from <http://republicans.veterans.house.gov/documents/vadodsha.asp>; Internet; accessed 13 November 2007.

³ Testimony of Dr. Michael J. Kussman, Acting Undersecretary for Health, Department of Veterans Affairs, U.S. House of Representatives, Subcommittee of Oversight and Investigations, March 8, 2007.

⁴ Testimony of the Honorable Patrick W. Dunne, Assistant Secretary for Policy and Planning, U.S. Department of Veterans Affairs, U.S. Senate, Committee on Veterans Affairs, October 17, 2007.

⁵ Public Law No: 110-181: National Defense Authorization Act for Fiscal Year 2008; available from <http://www.govtrack.us/congress/bill.xpd?bill=h110-4986>; Internet; accessed 15 February 2008.

⁶ Kimberly Amadeo, "U.S. Federal Budget FY 2008 - Discretionary Spending," Available from http://useconomy.about.com/od/fy2008budget/p/2008_Discretion.htm; Internet; accessed 12 January 2008.

⁷ U.S. House Resolution (H.R.) 2514: Assured Funding for Veterans Health Care Act, available from <http://www.govtrack.us/congress/bill.xpd?bill=h110-2514>; Internet; accessed 24 February 2008.

⁸ MHS Human Capital Strategic Plan 2008-2013, available from <http://www.health.mil/HCSP.pdf>; Internet; accessed 15 January 2008

⁹ Ibid, page 3.

¹⁰ U.S. Department of Defense, "FY 2008 President's Budget for Defense," February 5, 2007; available from <http://www.heritage.org/Research/Budget/bg2012.cfm>; Internet; accessed 15 October 2007.

¹¹ Department of Defense, Defense Health Program, (2002); available from <http://www.dtic.mil/comptroller>; Internet; accessed 23 October 2002, 56, 62.

¹² MHS Human Capital Strategic Plan 2008-2013; available from <http://www.health.mil/HCSP.pdf>; Internet; accessed 15 January 2008

¹³ Ibid., page 5.

¹⁴ Ibid., page 6.

¹⁵ Ibid

¹⁶ Department of Defense, TRICARE Management Activity (TMA), Policy Memorandum Number 5136.12 dates 31 May 2001; available from <http://www.tricare.mil/charters/tmacharter.html>; Internet; accessed 12 October 2007.

¹⁷ 2007 TRICARE Stakeholders Report; available from http://www.tricare.mil/stakeholders/downloads/stakeholders_2007.pdf ; Internet; accessed 12 February 2008

¹⁸ U.S. Congressional Budget Office, *Growth in Medical Spending by the Department of Defense* (Washington, D.C.: U.S. Congressional Budget Office, October 2007), Appendix A.

¹⁹ About VHA, United States Department of Veterans Affairs, Health Care – Veterans Health Administration; available from <http://www1.va.gov/health/AboutVHA.asp>; Internet; accessed 5 December 2007.

²⁰ Ibid

²¹ U.S. Congressional Budget Office, *The Healthcare System Care for Veteran's: An Interim Report December 2007* (Washington, D.C.: U.S. Congressional Budget Office, October 2007), 5.

²² Delivering on the Promise, Report to the President on Executive Order 13217; available from <http://www.hhs.gov/newfreedom/final/vavha.html>; Internet; accessed 3 March 2008.

²³ Disabled American Veterans, Why is VA Health Care Important?; available from http://www.dav.org/voters/mandatory_funding.html; Internet; accessed 12 February 2008.

²⁴ U.S. Congressional Budget Office, *The Healthcare System Care for Veteran's: An Interim Report December 2007* (Washington, D.C.: U.S. Congressional Budget Office, October 2007), 3.

²⁵ Delivering on the Promise, Report to the President on Executive Order 13217; available from <http://www.hhs.gov/newfreedom/final/vavha.html>; Internet; accessed 3 March 2008.

²⁶ Enrollment Priority Groups, VA Health Care Eligibility and Enrollment, United States Department of Veterans Affairs; available from <http://www.va.gov/healtheligibility/eligibility/PriorityGroups.asp>; Internet; accessed 12 February 2008.

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